PRIME TIME HEAD START

Permission to Release/Request Information
Consent for Release and Receipt of Child Records

Child's Name:_____Date of Birth: _____

As parent/guardian of the child named above, **I hereby grant Prime Time Head Start permission to:**

- ✓ Release records relevant to my child/family to
- ✓ Request records relevant to my child/family from

the following MEDICAL Professional:

_____Address: _____

Contact Person (if appl): _____

the following DENTAL Professional:

_____Address: _____

Contact Person (if appl): _____

including **the following** (as checked below):

- ✓ Family contact information (address, phone number, email)
- ✓ Child's health information
- ✓ Information regarding child's special needs (observations, individual education plan) if applicable
- ✓ Other _____

I also authorize staff of Prime Time Head Start and the above-named organization to **share information verbally**, as needed.

I understand that the confidentiality of any information identifying my child and/or myself will be maintained in accordance with Prime Time Head Start's policy regarding the Privacy of Child Records, and all applicable laws.

By signing below, I also acknowledge that:

- I may review the indicated information at any time.
- This authorization is voluntary, and I may refuse to sign it. My refusal to sign will not affect my eligibility for services or enrollment in the Prime Time Head Start program.
- I may also choose to revoke it at any time by notifying Prime Time Head Start in writing. I understand that if I revoke this consent, my revocation will not affect disclosures or receipts that have already been made.

Authorized by:

Parent/Guardian Name (PRINT):_____Phone:_____

Parent/Guardian Signature: _____Date: _____

Address:_____Email: _____