Community Action Team, CHILD & FAMILY DEVELOPMENT PROGRAMS

Parent/Guardian Consent to Exchange Confidential Information

Child's Name: ______________________________
DOB: ________________________________
Parent/Guardian Name:
____
Mailing Address:____________________________
City/State/Zip
____
Phone: ____________________________________

Name of Agency/Contact Person
____
____
Address: ___________________________________
____
Phone: ____________________________________
FAX: ______________________________________

____Income Verification
____Medical Information
____Dental Information
____Hearing Information
____Vision Information
____Immunizations
____Nutrition and Growth Information
____Social Service Information
____Mental Health Counseling/Consultation

____Psychological Test Results and Reports
____Ongoing Child Assessment
____Developmental Screenings
____Special Education Reports
☐IEP/IFSP ☐Statement of Eligibility
____Child Progress Reports
____Transition Meeting Information
____Other: _______________________________

By signing this form, you are giving permission for these agencies to share confidential information to support our work with you and your family.

Yes, I agree that the agency and/or person listed above may share and exchange only the information checked above about me and my family.

This permission is good for __________ days, but not to exceed 120 days.

I can cancel this at any time, but I understand this will not effect any information that has already been released. I understand that information about me and my family is confidential and protected by state and federal laws. I approve the release of this information, and understand what it means.

______________________________________ ______________________
Signature of Parent/Guardian Date

______________________________________ ______________________
Signature of Witness Date

FOR STAFF USE ONLY

I have explained to ________________________ the reason for this release, and the confidential information which might be involved. The name of the person and/or agency was listed before the above named parent/guardian signed this consent form and that nothing has been added or changed since the parent/guardian's signature was obtained. I also understand that any additional requests to give or obtain confidential information will require another signed consent form from the above named parent/guardian. I have read and explained this form to parents who cannot read.

________________________ ____________________ ____________________
Signature of Head Start staff Position Date signed

RETURN ALL INFORMATION TO: CHILD & FAMILY DEVELOPMENT PROGRAMS

Fax: (503)__________________________ Head Start Center ______________________