Stanislaus County Office of Education
Tom Changnon, Superintendent

Child & Family Services

Tony Jordan, Executive Director
1100 H Street • Modesto CA 95354 • (209) 238-1800 • FAX (209) 238-4217

CHILD FAMILY SERVICES
PARENT/GUARDIAN CONSENT FOR RELEASE OF INFORMATION

Name of Child: _____
(Last) (First) (Initial)

Date: _____ Date of Birth: _____

I hereby give the following agency(ies) permission to obtain information from my child's Head Start program, or release information to the specific Head Start site or agency listed below:

Name/Agency _____ Name/Agency _____
Address _____ Address _____
City _____ City _____
State/Zip _____ State/Zip _____

Name/Agency _____ Name/Agency _____
Address _____ Address _____
City _____ City _____
State/Zip _____ State/Zip _____

Check type of information requested or being sent:

__Educational (including speech/language) ___ Medical _____(specify if needed)
__Psychological __Nutrition ___Dental ___Other_____

Contact Information:
Parent/Legal Guardian Name: _____
Address: _____ Telephone: _____
City: _____ State: _____ Zip: _____

Head Start Program /Agency Name:_____
Head Start Representative: _____ Office/Center: _____
Address: _____ Phone:_____FAX:_____
City: _____ State: _____ Zip: _____

Distribution: *White:* Child's file *Yellow:* Agency *Pink:* Parent

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Parent /Guardian Consent for Release of Information

Name of Child: _____
(Last) (First) (Initial)

Date: _____ Date of Birth: _____

I request that the information released pursuant to this authorization be used for the following purposes only:

___ Educational Assessment ___ Other: _____
___ Educational Plans ___ Other: _____
___ Health Care Plans ___ Other: _____

Duration: This authorization shall become effective immediately and shall remain in effect until _____ (date) or for one year from the date of signature if no date is entered.

Revocation: I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Head Start agency listed on this form. Written revocation will be effective upon receipt, but will not apply to information that has already been disclosed in response to this authorization.

Redisclosure: I understand that protected health information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and it may no longer be protected by federal laws and regulations regarding the privacy of protected health information.

Health Information: I understand that authorizing the disclosure of health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form in order to assure medical treatment.

_____ _____
Parent/Guardian Signature Date

_____
Print Name

A copy of this authorization is as valid as the original. I understand that I am entitled to receive a copy of this authorization.

Distribution: *White:* Child's file *Yellow:* Agency *Pink:* Parent