



Head Start Authorization for Release of Information



Please fill out all sections of this form.

Patient Name: _____ Social Security #: _____
 Address: _____ Date of Birth: _____
 City: _____ State: _____ Zip: _____ Phone Number#: _____

Send Information From: (Request Information From)

Send to: (Head Start Program Address)

Floyd County Head Start
106 North Front Avenue
Prestonsburg, KY 41653
ATTN: _____

I would like the records from the following dates: _____ **through** _____.

(This can be a specific date or more general: Example June 2018 or September 2017-May2018).

Please check the records you would like:

- | | | |
|---|--|---|
| <input type="checkbox"/> Medical Exam/Physical | <input type="checkbox"/> Vision Exam | <input type="checkbox"/> Vision Screening |
| <input type="checkbox"/> Dental Exam | <input type="checkbox"/> Blood Lead Screening | <input type="checkbox"/> Developmental Screening |
| <input type="checkbox"/> Dental Treatment | <input type="checkbox"/> Hearing Screening | <input type="checkbox"/> Hemoglobin/Hematocrit |
| <input type="checkbox"/> Blood Pressure | <input type="checkbox"/> Other _____ | |

Sharing of Special Protected Records: I authorize the sharing of information about:

- a. The diagnosis or treatment of AIDS, including the results of HIV tests (the virus that causes AIDS) _____ YES _____ NO
- b. The diagnosis or treatment of drug and /or alcohol abuse, _____ YES _____ NO
- c. The treatment and/or consultation for mental health or psychiatric disorders _____ YES _____ NO

Reason records are needed (check all that apply)

_____ For Head Start Health Requirements _____ Personal Use _____ Other: _____

I understand that I do not have to sign this authorization and that the Big Sandy Area Community Action Program, Inc., may not condition treatment or payment on whether I sign this authorization. However, I understand that I have the right to revoke this authorization, in writing, at any time, and that the revocation will be effective except to the extent that the Big Sandy Area Community Action Program, Inc., has already taken action in reliance on my authorization. I further understand that I may inspect or copy the PHI to be used or disclosed.

My written statement that I want to revoke my authorization should be delivered to:

Floyd County Head Start 106 North Front Avenue; Prestonsburg, KY 41653 ATTN:

This authorization expires on (please list a specific date): _____

Or ninety (90) days from date signed (whichever occurs first) and will automatically become null and void without my express revocation.

Date

Signature of Parent/guardian

Relationship to Patient