Spokane County Head Start/ECEAP/EHS
AUTHORIZATION TO DISCLOSE AND RECEIVE INFORMATION

PARENT/CHILD INFORMATION

Child's last name ______________________ First ______________________ Birth date ______________

Parent/legal guardian ____

INFORMATION TO BE RELEASED FROM:

Name of facility or provider ____

Mailing address ____

Phone number __________________________ Fax number __________________________

ATTN ____

INFORMATION TO BE SENT TO:

Head Start/ECEAP/EHS site ____

Mailing address ____

Phone number __________________________ Fax number __________________________

ATTN ____

INFORMATION TO BE RELEASED: (check as appropriate)

☐ Hearing screening results ☐ Vision screening results ☐ IEP/IFSP

☐ Hematocrit results ☐ Developmental assessments ☐ Blood lead level results

☐ Other specific information ____

PURPOSE FOR WHICH THE DISCLOSURE IS BEING MADE

☐ To meet Head Start/ECEAP/EHS performance standard requirements

PARENT AUTHORIZATION

I understand that I may revoke this authorization, in writing, at any time. Information received via this request will not be re-disclosed to any other entity without an additional parent signed release. The information will be disposed of in accordance with state and federal laws and Head Start/ECEAP/EHS policies and procedures.

I give my specific authorization for these records to be released, excluding any State and/or Federally protected information.

Signature ____ Date ______________________
(Authorized parent, legal guardian, or authorized representative)

This authorization will expire at the end of the program year.

Copy - Parent