

Release of Information

Completing this release is voluntary and will not impact your eligibility for WIC or any other program/entity identified on this form.

I authorize the release of information for: Participant(s)/Patient(s) Name(s): The information is to be released from (identify name/location): □ Healthcare Provider: _____ □ WIC Program: ☐ Childcare Provider (including Head Start/Early Head Start): □ Other: _____ The information may to be provided to (identify name/location): ☐ Healthcare Provider: ______ □ WIC Program: ☐ Childcare Provider (including Head Start/Early Head Start): □ Other: The information that may be released from my records includes (i.e., the purpose): ☐ Any information from the record(s) that is requested by the receiving provider/program in the scope of their care and/or services of the participant(s) listed. □ Only information related to: **Release is valid until:** □ 1 year from the date signed □ Other date (specify): This information is to be released for a specific purpose only and may not be used by the recipient for any other reason. This information may not be shared with a third party. I understand that I may revoke this authorization in writing at any time; except for information that may have already been shared. If this authorization has not been revoked, it will terminate one year from the date it was signed. Participant/Parent/Guardian/Authorized Rep Signature Date