· HEAD START · EARLY HEAD START · OREGON HEAD START PRE-KINDERGARTEN · CAR SEAT LOAN PROGRAM	**Umatilla-Morrow Head Start, Inc.** 110 NE 4th Street Hermiston, OR 97838 (541) 564-6878 FAX (541) 564-6879	· WIC PROGRAM · CHILD CARE RESOURCE REFERRAL PROGRAM · HEALTHY START

Authorization for Release of Information: Families with Children

To Our Clients: We can help you better if we are able to work with other agencies that know you and your family. By signing this form, you are giving permission for these organizations to share information about you or your child's situation with us and for us to share information about you and your child's situation with them.

Your Name, Social Security Number and Date of Birth

Name:______________________ DOB:__________ SS#______________

Name: ______________________ DOB:__________ SS#______________

Your Child, Social Security Number and Date of Birth

Name:______________________ DOB:__________ SS#______________

I authorize any of the following individuals or agencies that I have initialed below to share and exchange information about me and my family with Umatilla Morrow Head Start, Inc. and for Umatilla Morrow Head Start, Inc. to share and exchange information about me and my family with these individuals or agencies.

(Please initial)	Mental Health (Write in agency or counselor name)
____ DHS Child Welfare	____ ______________________
____ DHS/CHS Self-Sufficiency	Alcoholic & Drug Treatment Agency
____ ESD:______________________	____ ______________________
____ School District:______________	Child Care Provider **(Write in Name)**
____ Hospital ____________________	____ ______________________
____ CAPECO____________________	Medical/Dental Providers **(Write in names of Providers)**
____ Department of Employment	___ ______________________
____ Health Department___________	___ ______________________
____ WIC________________________	
____ Other:______________________	

Including records of: (Please initial)

____Yes ____No Family History
____Yes ____No Employment/Unemployment
____Yes ____No Educational Reports
____Yes ____No Alcohol/Drug Treatment
____Yes ____No Mental Health/Psychiatric Services
____Yes ____No Medical/ Dental Treatment

Other Information:

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Alcohol/Drug, Mental Health, Psychiatric, Dental, and Medical Records include all aspects of diagnosis, treatment and prognosis. Educational records include both behavioral and progress reports.

Purpose: The information received will be **used to evaluate my situation and to plan for and coordinate services for me and my family**, or for other purposes as specified: ______________________

This permission is good for **one year** or until:______________________ (may **not** be for more than one year)

I can cancel this at any time, but I understand that the cancellation will not affect any information that was already released before the cancellation. I understand that the information about my case is confidential and protected by state and federal law. I approve the release of this information. I understand what this agreement means. I am signing on my own and have not been pressured to do so.

___Client ___Guardian
___Parent ___Legal Custody

.... Signature Date

.... Signature Date

.... Staff Signature Date

To those receiving information under this authorization: This information disclosed to you is protected by state and federal law. You are not authorized to release it to any agency or person not listed on this form without specific written consent of the person to whom it pertains unless authorized by other laws.

This is a true copy of the original authorization document ______________________ (Agency Staff Person)