

<ul style="list-style-type: none"> • HEAD START • EARLY HEAD START • OREGON HEAD START PRE-KINDERGARTEN • CAR SEAT LOAN PROGRAM 	Umatilla-Morrow Head Start, Inc. 110 NE 4 th Street, Hermiston, OR 97838 (541) 564-6878 FAX (541) 564-6879	<ul style="list-style-type: none"> • WIC PROGRAM • CHILD CARE RESOURCE REFERRAL PROGRAM
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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.

<p>(Please initial)</p> <p>____ DHS Child Welfare</p> <p>____ DHS/CHS Self-Sufficiency</p> <p>____ ESD: _____</p> <p>____ School District: _____</p> <p>____ Hospital _____</p> <p>____ CAPECO _____</p> <p>____ Department of Employment</p> <p>____ Health Department _____</p> <p>____ WIC _____</p> <p>____ Other: _____</p>	<p>Mental Health (Write in agency or counselor name)</p> <p>_____</p> <p>Alcoholic & Drug Treatment Agency</p> <p>_____</p> <p>Child Care Provider (Write in Name)</p> <p>_____</p> <p>Medical/Dental Providers (Write in names of Providers)</p> <p>_____</p>
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Including records of: (Please initial)

- | | | |
|--------------------------|--------------------------|------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Family History |
| <input type="checkbox"/> | <input type="checkbox"/> | Employment/Unemployment |
| <input type="checkbox"/> | <input type="checkbox"/> | Educational Reports |
| <input type="checkbox"/> | <input type="checkbox"/> | Alcohol/Drug Treatment |
| <input type="checkbox"/> | <input type="checkbox"/> | Mental Health/Psychiatric Services |
| <input type="checkbox"/> | <input type="checkbox"/> | 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.

Q Client	Q Guardian		
Q Parent	Q 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)