LOC ID _____

Lower Columbia College Head Start/EHS/ECEAP
Adult/Pregnant Individual Permission
to Reveal or Obtain Confidential Information

Please complete this form with **ALL** information.

Adult Name: _____ DOB: _____

Address: _____ Phone: _____

City/State: _____

I hereby authorize the exchange of information orally, in writing or electronically between the Head Start/EHS/ECEAP Program and the Agencies/Persons listed below for the purpose of meeting performance standard requirements and to provide ongoing care.

Name of Individual/Agency: _____

Address: _____ Phone: _____

City/State/Zip: _____ Fax/Email: _____

Check all that apply:

- ☐ Health/Medical Information
- ☐ Prenatal Records
- ☐ Dental
- ☐ Educational/IEP/IFSP
- ☐ Screening/Assessment
- ☐ Mental Health (_____ initials)
- ☐ AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus)
- ☐ Other: _____
- ☐ All of the Above

ADULT AUTHORIZATION

I understand that I may withdraw this authorization, in writing or at any time and it will not affect my enrollment. Information received through this request will not be re-disclosed to any other persons/clinics/agencies without an additional parent signed release. The information will be released in accordance with state and federal laws/FERPA and Head Start/EHS/ECEAP 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 after 18 months of signature date.

Lower Columbia College Head Start/EHS/
ECEAP PO Box 3010
Longview, WA 98632
360-442-2800 FAX: 360-442-2819
Email: headstart.info@lowercolumbia.edu

(C: 11/13; R: 04/22)