**FORM M**

## Stockbridge-Munsee Community | Electa Quinney Head Start

**AUTHORIZATION TO RELEASE INFORMATION**

W13429 Cherry Street Bowler, WI 54416 PH: 715.793.4993 FAX: 715-793-4494

**Child's Full Name** **Date of Birth**

**Previous Names/Nicknames**

I authorize the use of disclosure of the above-named individual's health information as described below

**INFORMATION RELEASED FROM:**
(The following facility is authorized to make the disclosure)

**Physician/Medical Facility**
**Address**
**City/State/Zip**
Telephone
**FAX**

**INFORMATION RELEASED TO:**
(May be disclosed to/ used by the following organization)

**Name** Stockbridge-Munsee Community Head Start
**Address** W13249 Cherry Street
**City/State/Zip** Bowler, WI 54416
Telephone 715-793-7993
**FAX** 715-793-4994

**TYPES OF INFORMATION TO BE DISCLOSED** (Check all applicable)

- ☐ - **Immunization Records**
- ☐ - **Nutrition/Height/Weight/Growth Charts**
- ☐ - **Medical Exams**
- ☐ - **Blood Lead – Lab Report**
- ☐ - **Vision Exams**
- ☐ - **Dental Exams**
- ☐ - **Hemoglobin – Lab Report**
- ☐ - **Mental Health Services (follow-up)**
- ☐ - Other: Click or tap here to enter text.

**PURPOSE OF DISCLOSURE** (Check all applicable)

- ☐ - **Disability Determination**
- ☐ - **At the Request of the Individual**
- ☐ - **Legal Investigation/Court Case**
- ☐ - **Other** Child's Head Start File

**NOTICE TO PATIENT**

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present a written revocation to the Medical Records Department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Unless otherwise revoked this authorization will remain in effect for**: the child's enrollment with Stockbridge Munsee Community Head Start**. If I fail to specify an expiration date, date, event or condition this authorization will expire in twelve months.

I understand that authorizing the disclosure of this health information is voluntary. I have read statements about charges and obtaining copies of medical records printed on the reverse of this form. I can refuse to sign this authorization. I understand that signing this form is not a condition for receiving treatment, payment for services or enrollment/eligibility for benefits. I may inspect or copy the information to be used or disclosed as provided in 45 CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by Federal confidentiality rules. If have a question about disclosure of my health information I can contact the Privacy Office. (A FAX copy/photo copy of this authorization shall be considered as valid as the original.)

**SIGNATURE**

**Parent Signature** **Date**
**If signed by Legal Representative/Relationship to Patient**

☐ - Patient Hand Delivered ☐ - Mailed ☐ - Faxed

**Date** **Initials of Individual Releasing**

**Patient Name** **Patient Phone Number**