

Head Start Authorization for Release of Information



	Please fill out all se	ctions of this form.
Patient Name:		Social Security #:
Address:		Date of Birth:
City:	State: Zip:	Phone Number#:
Send Information From: (R	equest Information From)	Send to: (Head Start Program Address)
		Pike County Head Start
		5279 North Mayo Trail
		Pikeville, KY 41501
		ATTN:
I would like the records from the	he following dates:	through
(This can be a specific date or more gene	ral: Example June 2018 or Sept	tember 2017-May2018).
Please check the records you would	like:	
□ Medical Exam/Physical	□ Vision Exam	□ Vision Screening
□ Dental Exam	□ Blood Lead Scree	ening Developmental Screening
□ Dental Treatment	☐ Hearing Screenin	g 🗆 Hemoglobin/Hematocrit
□ Blood Pressure	□ Other	
Sharing of Special Protected Recor	rds: I authorize the sharing	g of information about:
b. The diagnosis or treatment of drug a	and /or alcohol abuse,	sts (the virus that causes AIDS) —— YES —— NO —— YES NO lisorders YES NO
Reason records are needed (che	eck all that apply)	
For Head Start Health Req	uirements Perso	onal Use Other:
treatment or payment on whether I sign that any time, and that the revocation will be of	his authorization. However, I un effective except to the extent tha	Sandy Area Community Action Program, Inc., may not condition aderstand that I have the right to revoke this authorization, in writing, at at the Big Sandy Area Community Action Program, Inc., has already may inspect or copy the PHI to be used or disclosed.
Written statement that I want to revok	e my authorization should be	delivered to:
Pike CO Head Start 5279 North Mayo Tr	ail Pikeville KY 41501 ATTN	:
This authorization expires on (plea Or ninety (90) days from date sign express revocation.	nse list a specific date): ned (whichever occurs first) and will automatically become null and void without my
		Signature of Parent/guardian
Relationship to Patient		Relationship to Patient