Authorization to Release and Exchange Confidential Health Information Form - HS/EHS Potentially Life Threatening Conditions

Early Learning psesd excellence & equity in education Puget Sound Educational Service District

Authorization to disclose records of:			
NAME LAST	FIRST	MIDDLE	DATE OF BIRTH
THE FOLLOWING INFORMATION MAY HELP IN LOCATING RECORDS:		PARENT/GUARDIAN NAMES	
MEDICAID IDENTIFICATION NUMBER (FROM MEDICAL COUPON)		OTHER HEALTH INSURANCE	

Information released to: (completed by Staff)

SITE/PROGRAM NAME

HEAD START – PSESD, EARLY LEARNING HEALTH SERVICES

ADDRESS	CITY	STATE	ZIP CODE
800 OAKESDALE AVE SW	**RENTON**	**WA**	**98057**

TELEPHONE NUMBER (INCLUDE AREA CODE)	FAX NUMBER (INCLUDE AREA CODE)	E-MAIL ADDRESS
425-917-7745 / 253-778-7745	**888-979-5897**	**HEALTH@PUGETSOUNDHS.ORG**

REASON FOR RELEASE OF INFORMATION:

At the request of the parent/legal guardian for the health, safety, and educational purposes of their child while enrolled in Head Start.

Information to be released from:

SOURCES: I authorize mutual exchange of information about my child as described below. Information may be provided by:
(Check all that apply)

❒ verbally ❒ computer data transfer ❒ mail ❒ fax ❒ hand delivery

PROVIDER _____

ADDRESS _____

TELEPHONE NUMBER _____ FAX NUMBER _____

Records: I authorize the following records/information to be disclosed:

❒ MEDICAL EXAM/TREATMENT ❒ MEDICATION ADMINISTRATION
❒ DENTAL EXAM/TREATMENT ❒ CHILD HEALTH PLAN
❒ IMMUNIZATION RECORDS ❒ OTHER_____

This permission is valid for ❒ 90 days ❒ Current School Year or ❒ until _____ (date or event).

- I may revoke or withdraw my permission in writing at any time, but that will not affect information already disclosed.
- I understand that these records will be treated as confidential by the Early Learning Program.
- A copy of this form is valid to give permission to disclose records.
- Information disclosed through this authorization may be shared and is no longer protected by HIPAA.
- Authorizing the disclosure of this information is voluntary. I do not need to sign this form in order to assure treatment or payment.

AUTHORIZATION BY (SIGNATURE)	RELATIONSHIP TO CHILD	DATE SIGNED	TELEPHONE # (INCLUDE AREA CODE)

PRINT NAME	INTERPRETER (SIGN AND PRINT NAME, IF APPLICABLE)

If I am not the person who is the subject of the records, I am authorized to sign because I am the:

❒ Parent of minor ❒ Legal Guardian ❒ Other:_____