East Missouri Action Agency
Head Start
403 Parkway Drive, PO Box 308
Park Hills, Missouri 63601

Authorization for Release of Information

I hereby authorize and request the below named provider/providers to release full and complete information as to results from any medical examinations and treatments, dental examinations and treatments, immunization records, hemoglobin/hematocrit testing, lead screening and /or testing, HCY Screenings, WIC information or any other medical records deemed necessary by Head Start and the parent/guardian. The information released will remain with Head Start and not be shared with any other agency unless written permission is obtained from parent/guardian. This release will stay in effect for one year after signature date or released is revoked in writing.

Child's Name and Address _____ Date of Birth _____

_____

Releasing Service Provider/Providers

Name	Address	Phone Number
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

Comments:

_____

_____

Parent/Guardian Signature: _____ Date_____

Head Start Staff Signature: _____ Date_____