Tri-County Head Start/Early Head Start

Consent to Release Information

As parent/guardian of _____ DOB _____

I hereby give my consent to Tri County Head Start/Early Head Start, to obtain from and to release to the following agencies and/or person(s) pertinent social, medical, educational, and other information concerning my child. I understand that any information obtained or released will be used for his/her benefit.

This consent is valid for the _____ school year.

I understand that Tri County Head Start/Early Head Start may exchange information with the agencies or individuals listed below. I have marked yes by those agencies or individuals with which you may exchange information.

Yes	No	
		Physician:
		Dentist:
		WIC:
		Health Dept:
		Other:

By signing this authorization, I release Tri County Head Start/Early Head Start, its' agents and staff, and the specified agencies listed above, from any legal liability resulting from the disclosure or acquisition of information released or obtained on the above-named child.

This authorization form was explained in full to me on the above-named child, including the purposes of the release and the disclosure, which might be reasonably anticipated.

_____ _____

Parent/Guardian Signature Date

_____ _____

Staff Signature Date