

**Pocatello/Chubbuck School District #25 Head Start  
330 Oakwood Drive  
Pocatello, ID 83204**

**AUTHORIZATION FOR RELEASE OF INFORMATION**

I give my permission for the exchange of the following information between your office and the Head Start program:

<input type="checkbox"/> Physical exam and follow-up treatment	Name of Provider
<input type="checkbox"/> Dental exam and treatment	_____
<input type="checkbox"/> Immunizations	_____
<input type="checkbox"/> Medical Records	_____
<input type="checkbox"/> WIC	_____

Child's Name: (print) \_\_\_\_\_

Parent's or Guardian's Name: (print) \_\_\_\_\_

Parent's or Guardian's Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Witnessed by: \_\_\_\_\_

ALL INFORMATION WILL REMAIN CONFIDENTIAL

\_\_\_\_\_  
Head Start Health Services Manager



H--9 Authorization for Release of Information Instructions

- \* Completed in ink at the beginning of the year, usually at the intake appointment.
- \* Used by the Health Services Manager, or designee, to request information from providers for health and dental services received by an enrolled child.
- \* Filed in the family file at the end of the year if not needed.