# Jefferson County Head Start Consent to Exch Health Info

Name ______________________ Birthday ______________ Location ______________________

Date Completed [ ] Current School Year
☐ 2020 - 2021
☐ 2021 - 2022

## Consent to Exchange Health Information

-As the parent/guardian of this child, I hereby consent to the release of the following information indicated below, to be obtained and held by Jefferson County Head Start.-I authorize communication and exhange of information between Jefferson County Head Start and the provider listed below. I have indicated information/documention below that may be released.

## Primary Physician/Clinic

| Provider/Clinic Name: | Address: | Phone Number: | Fax: |
|---|---|---|---|
| | | | |

## Primary Dentist/Clinic

| Dentist/Clinic Name: | Address: | Phone Number: | Fax: |
|---|---|---|---|
| | | | |

## Medical Specialist or Eye Dr (i.e. ENT, Neurologist, Children's Hospital Clinic, Optometrist/Ophthalmologist etc.)

| Provider/Clinic Name: | Address: | Phone Number: | Fax: |
|---|---|---|---|
| | | | |

| Provider/Clinic Name: | Address: | Phone Number: | Fax: |
|---|---|---|---|
| | | | |

| Provider/Clinic Name: | Address: | Phone Number: | Fax: |
|---|---|---|---|
| | | | |

## Information to be Released

Please check below to indicate the type(s) of information you authorize the above listed provider to release to Jefferson County Head Start.

☐ Physical Exam Form (including vitals & lab results for Lead, Hgb/HCT, and Tuberculosi ☐ Immunization Record

☐ Dental Exam & Follow-Up Treatmen ☐ Vision Exam & Follow-Up Treatmen ☐ Developmental/Health Screenings

☐ Special Diet Statement ☐ Health Care Action Plan

☐ Diagnostic Assessments/Evals (OT and or PT, speech & language pathology, phychological, social-emotion

☐ Other (please specify) ______________________________

## Signatures

By signing below, you are stating the following:- I understand that this information is being shared to meet program performance standards/requirements to plan comprehensive services and coordinate service delivery.- This consent is valid for existing records and those created after the date of signature/consent, my consent is voluntary.- I understand that I can revoke this consent at any time except to the extent that action has already been taken in reliance on it and that this consent/authorization will automatically expire 12 months from the date of my signature. By signing below, I am confirming that I have read, understood and agree to the above.

| Parent/Guardian Name | Parent/Guardian Signature | Date |
|---|---|---|
| | | |

| Parent/Guardian Name | Parent/Guardian Signature | Date |
|---|---|---|
| | | |

| Head Start Staff Verified By: | Date |
|---|---|
| | |

☐ Declined Consent to Exchange Health Information (only check if you do NOT give Head Start Permission)