· HEAD START · EARLY HEAD START · OREGON HEAD START PRE-KINDERGARTEN · CAR SEAT LOAN PROGRAM	**Umatilla-Morrow Head Start, Inc.** 110 NE 4th Street, Hermiston, OR 97838 (541) 564-6878 FAX (541) 564-6879	· WIC PROGRAM · CHILD CARE RESOURCE REFERRAL PROGRAM

Authorization for Release of Information: Families with Children

To Our Clients: We can help you better if we are able to work with other agencies that know you and your family. By signing this form, you are giving permission for these organizations to share information about you or your child's situation with us and for us to share information about you and your child's situation with them.

Your Name, Social Security Number and Date of Birth

Name: Juanita Estevan DOB: 8-16-81 SS# 561-38-7934

Name: _____ DOB: _____ SS# _____

Your Child, Social Security Number and Date of Birth

Name: Pedro Estevan DOB: 8-22-05 SS# 620-09-8995

I authorize any of the following individuals or agencies that I have initialed below to share and exchange information about me and my family with Umatilla Morrow Head Start, Inc. and for Umatilla Morrow Head Start, Inc. to share and exchange information about me and my family with these individuals or agencies.

(Please initial)

- ___ DHS Child Welfare
- JE DHS/CHS Self-Sufficiency
- JE ESD: Umatilla 10/2/09
- JE School District: Hermiston
- JE Hospital Good Shepherd
- JE CAPECO
- ___ Department of Employment
- JE Health Department
- JE WIC
- JE Other: Lifeways 12/10/09

Mental Health (Write in agency or counselor name)

Alcoholic & Drug Treatment Agency

Child Care Provider **(Write in Name)**

JE Lucy Estevan

Medical/Dental Providers **(Write in names of Providers)**

JE Dr. Garcia

JE Advanced Pediatrics

Including records of: (Please initial)

- JE Yes No Family History
- JE Yes No Employment/Unemployment
- JE Yes No Educational Reports
- Yes JE No Alcohol/Drug Treatment
- Yes JE No Mental Health/Psychiatric Services
- JE Yes No Medical/ Dental Treatment

Other Information:

Alcohol/Drug, Mental Health, Psychiatric, Dental, and Medical Records include all aspects of diagnosis, treatment and prognosis. Educational records include both behavioral and progress reports.

Purpose: The information received will be **used to evaluate my situation and to plan for and coordinate services for me and my family**, or for other purposes as specified: _____

This permission is good for **one year** or until: _____ (may not be for more than one year)

I can cancel this at any time, but I understand that the cancellation will not affect any information that was already released before the cancellation. I understand that the information about my case is confidential and protected by state and federal law. I approve the release of this information. I understand what this agreement means. I am signing on my own and have not been pressured to do so.

☐ Client ☐ Guardian

☒ Parent ☐ Legal Custody

Juanita Estevan 7/15/09

Signature Date Signature Date

Ana M Reynaud 7/15/09

Staff Signature Date

To those receiving information under this authorization: This information disclosed to you is protected by state and federal law. You are not authorized to release it to any agency or person not listed on this form without specific written consent of the person to whom it pertains unless authorized by other laws.

This is a true copy of the original authorization document _____ (Agency Staff Person)