Authorization for Release of Information-Sample

Household ID# _____ **Date:** _____

I give my consent to the _____ WIC Program to release and exchange information about myself and/or my minor children.

Name _____ DOB _____ Name _____ DOB _____
Name _____ DOB _____ Name _____ DOB _____
Name _____ DOB _____ Name _____ DOB _____

Initial the entities, programs, or persons you agree to release and exchange information:

___ Home Visiting ___ Child and Teen Check Up ___ Immunization ___ Car Seats
___ Follow Along ___ ECFE/School District _____ ___ Head Start ___ One Call Now
___ Medical Provider/Health System/Clinic _____
___ Other provider/Organization _____

Initial Information you agree to release and exchange:

___ All Information that I have provided to the WIC Program, measurements and assessments made by the WIC Program, appointment dates and times, and whether I participate in the WIC program.
___ My participation in the WIC Program, my contact information, and my appointment dates and times.
___ Other information _____

Initial the methods you agree to exchange information with the WIC Program:

___ Phone Call/Voice Message ___ Text Message ___ Email

I understand that sending information electronically may not be secure. I assume the risk that persons other than the intended recipient may observe information sent by these media. Depending on my phone plan, there may be charges I will be responsible for, and I can ask to stop receiving these types of communication at any time.

This information will be used to:

- Contact me about WIC appointments or provide information by phone, email, or text.
- Provide services that I am eligible for and wish to participate.

How will my privacy be protected? The information about me is private and protected by federal and state privacy laws. The Minnesota WIC Program will not release identifying information to any unauthorized person without my permission. After the information is disclosed to other public health programs, the information will be protected by the Minnesota Government Data Practices Act. Under that Act, health information about me is private. The staff of the public health programs will have access to the information to the extent needed to perform their job duties for the programs. My medical doctor must protect the privacy of my health information under federal and state privacy laws.

Whether I need to sign? I understand that I do not have to agree to the release of information described in this document. I also understand that refusing to sign this authorization will not affect my eligibility or participation in the WIC Program or any other public health program, will not affect the current or future care I receive from any health care provider, and will not cause any penalty or loss of benefits to which I am otherwise eligible. However, if I do not sign this authorization and participate in more than one program, I may be asked the same health questions or take the same measurements more than once.

Cancelling my permission: I may cancel my permission at any time. In order to cancel my permission, I need to send or deliver a letter to _____ WIC program and include in the letter my request that my permission be cancelled, my name and date of birth, and my signature. This authorization expires _____ year(s) from the date of my signature, unless it is revoked at an earlier date by me.

_____	_____	_____
Date of Signature	**Signature of Participant, Parent or Guardian**	**Printed Name**

10/2018