



CONCHO VALLEY COUNCIL OF GOVERNMENTS



CVCOG RURAL HEAD START
325-944-9666

SAISD HEAD START/
EARLY HEAD START
325-947-3703

**SAISD Head Start/Early Head Start
"Parent/Guardian Consent to Exchange Information"**

Child's Name: _____ Social Security #: _____ DOB: _____

Address: _____ Telephone # _____

I hereby authorize Head Start/Early Head Start to exchange social, medical, or other information with the agency listed below. Information will remain confidential, and such information will be used to give your child appropriate services. The information may be used for determine if eligibility of a disability, or to develop an individual education plan. It may also be used to receive in-depth evaluation (physical, speech, or occupational therapy, for example), which may or may not recommend placement in special programs. At times, it may be necessary for a professional to supervise your child while performing necessary exams (such as vision or hearing screening) outside of the classroom. I understand that this consent is valid for a period not to exceed one year from the date signed. This consent releases both agencies and their staff from all legal liability that may arise from the release of the information.

Please check the type of information requested:

- Complete Health Record
- Billing Records
- Medical Reports
- Dental Exam
- Discharge Summary
- Physical Exam
- Laboratory Test Results
- Progress, Evaluation, Screen
- Other (list) _____

Please check the purpose of request:

- Treatment/Consultation
- Nurse Request
- In-depth Evaluation
- Billing or Claims
- Special Services
- Appointment Date
- Special Services
- Exchange Information
- Consent for Supervision
- Other (list) _____

Information to be exchanged between the following:

SAISD Head Start/Early Head Start

1621 University Avenue

San Angelo, Texas 76904

Time limit and right to revoke: Except to the extent that action has already been taken in reliance on this authorization at any time I can revoke this authorization by submitting a notice in writing to the Health Coordinator at SAISD Head Start/Early Head Start, 1621 University Avenue, San Angelo, TX 76904. Unless revoked, this authorization will expire one year from date of signature.

Drug/Alcohol, Psychiatric, and or HIV/AIDS Release I understand that the requested information may contain reference to or results from HIV/AIDS testing and treatment, drug/alcohol abuse, psychiatric care, sexually transmitted disease, or other sensitive information. I authorize the release of such confidential information to the indicated party, unless prohibited in writing.

Signature of Patient or Personal Representative I understand that I do not have to sign this authorization and my treatment or payment for services will not be denied if I do not sign this form. I can review or receive a copy of the protected health information to be disclosed. I authorize SAISD Head Start/Early Head Start to use and disclose the protected information specified above.

Parent or Guardian Signature

Date