State of Illinois
Department of Human Services - IMSHS

PARENT/GUARDIAN PERMISSION TO REVEAL CONFIDENTIAL INFORMATION

I give the _____ permission to obtain from or give to the following
(Head Start Program)

agencies and/or persons pertinent social, medical or other information about _____
(Name of Child)

for whom I am legally responsible for a period not to exceed _____ .

In granting such permission, I understand that such information will remain confidential to all other parties and that such information will be used only to give the child named above the best available professional help.

	Name of Agency or Person	City
Nutritionist:		
Medical Provider:		
Health Department:		
Dental Provider:		
Mental Health Consultant:		
Woman, Infant & Children:		

All Migrant Even Start Staff

I release the _____ and its staff from any legal liability
(Head Start Program)

for disclosing or acquiring information which I have permitted by signing this form.

I also release the above persons and/or agencies from any legal liability for giving information to the

_____ for the period stated above.
(Head Start Program)

_____ _____
(Signature of Parent or Guardian) (Date)

I explained to _____ the purpose of this release and the
(Name of Parent or Guardian)

purpose of this release and the disclosure which might reasonably be anticipated.

_____ _____
(Signature of Head Start Representative) (Date)