State of Illinois Department of Human Services
Migrant and Seasonal Head Start

AUTHORIZATION TO RELEASE INFORMATION

Parent's name _____

Child(ren)'s name _____

I authorize _____ Migrant and Seasonal Head Start program to release the following information:

_____ my family's address and phone number to Illinois State Board of Education Migrant Education program,

_____ health and other information contained in family and child files, for review by Illinois Department of Human Services Migrant and Seasonal Head Start personnel, and by Administration of Children and Families personnel.

I understand that the above-mentioned named agency/person/facility has a right to inspect and copy the information disclosed. I understand that I may revoke the release of information at any time, in writing, except where the agency has already made disclosures in reliance upon my prior authorization. I understand that no revocation of this consent shall be effective to prevent disclosure of records and communications until it is received by the Migrant and Seasonal Head Start program. It is my understanding that the records and communication to be disclosed may contain information about diagnoses/evaluation/treatment/developmental disabilities/referrals, and that my signature indicates my informed consent.

Parent's (or Guardian's) signature: _____ Date: _____

Relationship to Migrant and Seasonal Head Start child(ren): _____

Witness signature: _____ Date: _____

THIS AUTHORIZATION EXPIRES 360 DAYS AFTER IT IS SIGNED UNLESS REVOKED EARLIER.

Notice to whomever disclosure is made: This information has been disclosed to you from records whose confidentiality is protected by state and federal law. These laws prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or his or her parents or legal guardians. A general authorization for release of medical or other information is not sufficient for this purpose.