Northwestern Ohio Community Action Commission
HEAD START
Guiding Children and Families Toward Success

1933 E Second Street
Defiance, OH 43512
PH: 419-784-2150
Fax: 419-784-5048

Release Of Information

_____ _____ _____
Participant's Name Date of Birth Center

SECTION 1: Type of records authorized for release, exchange or discussion.

I, _____, hereby authorize the release, exchange or discussion of the
Full Name of Parent/Legal Guardian
following information regarding my child named above to NOCAC Head Start.

This information will be used to assist in determining future education plans and special needs for my child. I understand that the information is protected by law and may not be re-disclosed without my written authorization or as otherwise authorized by law; however, I understand that the releasing agency cannot control the recipient's use of the information.

Medical/Dental Information

- ☐ Hearing Evaluations and/or Screenings
- ☐ Vision Evaluations and/or Screenings
- ☐ Dental Examinations and/or Oral Health Treatments
- ☐ Hematocrit/Hemoglobin and/or Lead Screen Results
- ☐ Examinations, Physicals or Well Child Checks
- ☐ Medical Exam Information and/or Chronic Condition Treatment Plans
- ☐ Allergy Treatment Recommendations

Educational Information

- ☐ Mental Health Services, Progress Notes, Diagnosis, Treatment Plan, Evaluation Results
- ☐ Developmental Evaluations, Diagnosis, Progress Notes
- ☐ IEP, IFSP forms
- ☐ Educational records, Evaluation Results
- ☐ Kindergarten Readiness Assessment

Other

- ☐ Please Specify _____

SECTION 2: Request records from provider below

Individual/Organization/Provider _____

Phone Number _____ Fax Number _____

Complete Address _____

SECTION 3: Signature and Staff Certification

This consent form expires the final day of the current school/program year from the date of parent/legal guardian's signature unless revoked by me in writing.

_____ _____
Parent/Legal Guardian Signature Date

_____ _____
Witness Signature Date