



Head Start

"Building partnerships, changing lives"



Consent to Disclosure of Confidential Information

Student:	DOB:
Address:	Campus:
City: State:	Zip:
Parent:	Parent Phone:

To the Parent: Head Start is asking that you authorize the person or agencies named below to disclose confidential information regarding the above named child.

RECORDS TO BE RELEASED TO:	PURPOSE OF RELEASE:
<input type="checkbox"/> Parent/Guardian	<input type="checkbox"/> Parental Review
<input type="checkbox"/> School District/ Child Care	<input type="checkbox"/> Documentation of Records
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:

Please check the appropriate boxes below. For more information contact the Family Service Worker.

<input type="checkbox"/> Yes <input type="checkbox"/> No	I have been fully informed in my native language or other mode of communication and understand the request for consent, as described above. This information will be disclosed upon receipt of my written consent.
<input type="checkbox"/> Yes <input type="checkbox"/> No	I understand that my consent is voluntary and may be revoked at any time. I understand that I cannot reverse any actions that occurred when consent was given and before revoked. My consent will expire one year from the date it was signed.

I have been advised of my rights under the Family Educational Right and Privacy Act (FERPA). I understand my child's records will be kept confidential and may be released only to agencies authorized by me.

Signature of Parent: _____ Date: _____

Signature of Staff: _____ Date: _____

Effective Date: 2-25-19