WIC Nutrition Program
Authorization to Release or Obtain Information

We are committed to the privacy of your information.
Please read this form carefully.

Child's Name	Date of Birth	WIC Clinic
Parent/Guardian's Name:		
I give WIC permission to: ☐ release health information ☐ obtain health information		

Send my information to:

Name
Address
City, State, Zip Code
Phone Fax No.

Receive my information from:

Name
Address
City, State, Zip Code
Phone Fax No.

Please complete the following:

☐ Hgb/Hct: Date:	☐ Lead: Date:
☐ Height/Length: Date:	☐ Weight: Date:
☐ If child is unable to be present at WIC appointments, please list reasons:	

What is the purpose of the release? Please check or write a response.

☐ **To coordinate or manage child's care** ☐ **To be used to determine eligibility for the WIC Nutrition Program**
☐ **Other:**

Check all current medical conditions that apply:

☐ Bronchitis (3 episodes in last 6 months)	☐ Persistent Asthma requiring daily medication
☐ Failure to Thrive (specify underlying condition):	☐ Food Allergies (specify):
☐ FAS/FASD	☐ Substance Disorder in Utero (specify):
☐ Diabetes: ☐ Type 1 ☐ Type 2	☐ Pneumonia (within last 6 months)
☐ Low Head Circumference	☐ GI Disorder (specify):
☐ Other (specify any other conditions which may potentially affect nutrition status):	
Provider Signature:	**Date:**

D**rug/Alcohol (Substance Use Disorder) Referral or Services** □ Include **all** my information in the release, or:
□ Include only the **specific** drug/alcohol records checked: □ Diagnosis and treatment □ Clinical notes and discharge summaries □ Drug/Alcohol history or summary □ Payment or claims information □ Living situation and social supports □ Medication, dosages, or supplies □ Lab results □ Other:
HIV/AIDS Status/Test Results: □ Include this information in the release
Please note: Maine law requires us to tell you of possible effects of releasing HIV/AIDS information. For example, you may receive more complete care if you release this information, but you could experience discrimination if your data is misused. **DHHS/WIC** will protect your HIV data, and all your information, as the law requires.
Mental Health Information: □ Include this information in the release
□ I want to review my mental health/behavioral health record before release. I understand that the review will be supervised. **Please note**: Maine law allows health care providers and health plans to share this information with other health care providers and health plans to coordinate your care (to help take care of you) so long as we make a reasonable effort to notify you of the release.

I understand and agree that:

- My health information may be shared in written, spoken and/or electronic format.
- This form will expire **one year** from the date below unless I revoke (take back) my permission sooner.
- To take back my permission, I will contact the WIC office where I receive services. I understand that WIC may have released information prior to this time with my permission.
- If I take back my permission or refuse to release some or all of my information, my choice could lead to an improper diagnosis and/or treatment.
- I permit the people and/or offices listed on this form to speak to each other for the purpose(s) on this form.
- Health information from other providers (such as doctors, hospitals, and counselors) in my WIC file is included in this release.
- WIC offices will keep my information confidential as required by law. If I choose to share my information with others who are not required by law to keep it private, it may no longer be protected by federal confidentiality laws.
- If alcohol or drug treatment or program records are included in this release, WIC will include a notice saying that such information may not be re-released or shared without my written permission.

I am signing this form voluntarily. I have the right to a signed copy of this form if I request one.

Date: _____ **Signature** _____
WIC Participant

Date: _____ **Signature** _____
WIC Program Representative

This organization is an equal opportunity provider.