Return this form to:

Authorization for Release of Information for Special Formula Prescriptions

To: _____ Fax: _____

Participant's Name: _____ DOB: _____

Parent/Guardian's Name: _____ WIC Clinic: _____

My consent to authorize the release of information for special/medical formula prescriptions and supplemental foods is effective for _____ months (not to exceed 12 months).

- The WIC program may request information from my health care provider about medical formulas and supplemental foods for the participant named above.
- The WIC program may release information to my health care provider regarding medical formulas and supplemental foods for the participant named above.
- I understand that I can cancel this authorization at any time by notifying my local WIC office.
- I am entitled to a copy of this form.

Signed: _____ Date: _____
Parent/Guardian

Signed: _____ Date: _____
WIC Program Representative

This institution is an equal opportunity provider.