Doña Ana County Head Start
Agency Release of Information

Parent Name_____ Child's Name_____ Child's DOB_____

I hereby authorize _____: ☐ obtain from the following ☐ release to the following

Name of Agency:_____

Address:_____

City/State/Zip Code:_____

Phone Number:_____ Fax Number_____

The documents to be released are described or listed as:

☐ Copy of File
☐ Disability Information
☐ Legal Documentation
☐ Family Service Information
☐ Health Information
☐ Mental Health Information
☐ Education Information
☐ Other_____

I understand that my authorization will remain effective from the date of my signature until_____, and that the information will be handled confidentially in compliance with all applicable federal laws.

I understand that I may see information that is to be sent, and I may revoke the authorization at any time by written, dated communication.

I release Doña Ana County Head Start and it's staff from any legal liability for disclosing or acquiring information, which I have permitted by signing this form.

I have read and understand the nature of this release.

_____ _____
(Signature of Parent/Legal Guardian) (Date)

I have explained to _____the purpose of this release
(Print Parent/Legal Guardian)
and the disclosure which might reasonably be anticipated.

_____ _____
(Signature of Head Start Staff) (Date)

College of Education
Dona Ana County Head Start, MSC 3R
P.O. Box 30001
Las Cruces, NM 88003-8001
Phone: 575 646-8910 or
Health Specialist: 575- 646-8902

Fax: 575 646-3047