THE OHIO STATE UNIVERSITY

Parent/Guardian Authorization to Exchange Information

The Ohio State University Early Head Start Partnership Program will offer many services to your child and family. In order for the program to be most effective, the services listed below will be working together to meet the needs of your child, family and the requirements of the program. By signing this document you will allow the partnering agencies to share information regarding your child and family for the purpose of providing continuity of care.

I, ____ (parent/guardian), the parent/guardian of ______________________________ (child's name), hereby authorize The Ohio State University Early Head Start Program and its partnering agencies listed below to share pertinent program information related to health, education, development, nutrition, behavioral health and social services. I understand my family's information will be protected by state and federal laws of confidentiality.

Partnering Services:
The Ohio State University Early Head Start Program
Child's Physician/Medical Practice__________________________________ Fax (   ) ________________
Center/Provider's Name ____

- Children's Hunger Alliance
- Columbus Public Health Department
- Community Properties of Ohio
- Directions for Youth and Families
- Franklin County Board of Developmental Disabilities
- Franklin County Department of Job & Family Services
- Franklin County Family & Children First/Help Me Grow
- Moms2B
- Nationwide Children's Hospital
- New Directions Career Center
- Ohio State University Colleges and Departments
- Ohio State University Nisonger Center
- St. Vincent Family Center
- YMCA of Central Ohio

I understand this exchange of information is valid for the duration my child is enrolled in the OSU-EHS program. This exchange of information has been explained to me by ______________________________ (staff), and I understand the authorization is voluntary. I may revoke this consent at any time with written notice. If I revoke the consent, it will end all sharing of information from the date written notice is received but will not change the information that has been shared previously.

____
Printed Name of Parent/Guardian

____ ____________________
Signature of Parent/Guardian Date

____ ____________________
Child's Name Date of Birth

I, ____ (staff) have discussed this exchange of information with the parent/guardian listed above. I believe the parent/guardian fully understands this release and is giving informed and willing consent.

____
Printed Name of Witness

____ ________________
Signature of Witness Date

Phone Number: __________________________________

EHS-CC EARLY HEAD START CHILD CARE