Promise Early Education Center
The Head Start Program of Androscoggin County
P: (207) 795-4040 F: (207) 795-4044

Authorization to Release Protected Information

Name: _____ **Date of Birth:** _____

Send Information From: (Request Information From)

Send to: (Head Start Program Address)

Promise Early Education Center
269 Bates Street, Lewiston, ME 04240
Fax# **888-502-1522**
Attn: Norma Larocque

Please check the records you would prefer:

☐ **Most Current Records**	☐ **Dental Records**
☐ **Physicals/WCC** ☐ **Immunizations** ☐ **Lead/HGB/HCT/Labs**	☐ **Office visits** ☐ **Medication/Prescriptions/Appliances**
☐ **Surgical Services (discharge summary, consults, radiology, Care Plans)**	☐ **Home Health (Plan of care, orders, visit notes)**
☐ **Emergency Department (discharge summary, care plan)**	☐ **Other (Consent to Speak)**

Please Circle

authorized disclosure of any information relating to the diagnosis and/or treatment of **Mental Health** **__ Do __ Do Not**

authorized disclosure of information which refers to **HIV, Infection Status and/or Treatment** **__ Do __ Do Not**

authorize disclosure of any information relating to Alcohol and/or Drug Abuse __ Do __ **Do Not**

Reason records are needed (check all that apply)

_____For Head Start Health Requirements _____Personal Use _____Other: _____

I understand that: I do not have to sign this authorization for Promise Early Education Center. I can refuse to disclose some or all information in my record. I can revoke all or part of this authorization at any time. I understand I am entitled to a copy of this authorization at any time.

Written statement that I want to revoke my authorization should be delivered to:
Promise Early Education Center, 269 Bates St., Lewiston, ME 04240 ATTN:

This authorization is effective for one (1) year from the date of signing. I authorize future disclosures to the same individual and/or entity during this time period pursuant to this authorization.

_____ _____
Date **Signature of Parent/guardian**