Pueblo of Isleta
Early Head Start, Head Start & Child Care
P.O Box 579
Isleta, NM 87022
Phone: 505-869-9796 Fax: 505-7578

Authorization for Release of Information for Services

Child Name: _____ Date of Birth: _____

This authorization allows the Pueblo of Isleta Head Start & Child Care to obtain and/or share specific confidential information about you and/or your child/children. You are entitled to a completed copy of this authorization form**.** If you have a disability and you require this authorization in an alternative format or require a special accommodation to complete this form, you may request assistance from staff at the Pueblo of Isleta Head Start and Child Care.

Name (First, Last) (Please Print)	Date of Birth (mm/dd/yyyy) / /
Address (Street or P.O. Box, City, State, Zip Code)	
Phone Number	

1. This authorization applies to information to be: ☐ **Released by** ☐ **Shared to**

Name of Individual and/or Organization
Individual and/or Organization Address (No. and Street, City, State, Zip Code

2. The purpose/need for this disclosure or sharing is: _____
3. Date(s) of service:_____
4. The information to be disclosed/shared(specify)_____
   _____
   _____
   _____
5. This information shall be disclosed to or shared from the following individual or organization:

Name of Individual or Organization: **Pueblo of Isleta Early Head Start, Head Start & Child Care**
Individual Organization Address (No. and Street, City, State, Zip Code) **PO Box 579, Isleta, NM 87022**

6. This authorization will expire in **one (1) year** unless another expiration date is specified here: ___/___/___ **(mm/dd/yy)**

Statement of Understanding: I understand that I have a right to revoke this authorization in writing at any time to the Isleta Head Start and Child Care and the revocation will not apply to information that has already been released in response to this authorization. This authorization is invalid if the expiration date is passed or if the circumstance no longer exists. I understand that unless I revoke this authorization as stated above, this authorization will expire in (one) year unless I have specified a different date of expiration. I understand that authorizing the disclosure of this information is voluntary. I can refuse to sign this authorization. I understand that I have a right to limit the information disclosed.

7. I authorize the use, disclosure and sharing of the information as described above.

_____ _____
Signature of Parent/Guardian Date

_____ _____
Relationship to Child/Children Date

_____ _____
Signature of Verifying Staff Member Date