State WIC ID: ____

Authorization to Release and Exchange Information

Blue Earth County WIC Program – (507) 304-4163

I give my consent to the Blue Earth County WIC Program to release and exchange information about myself and/or my minor children.

Participant's Name: ____________________________ **DOB:** _____________

Initial the entities, programs, or persons you agree to release and exchange information:

___ MCH Home Visiting ___ Child and Teen Check Up ___ Financial Assistance ___ First Steps
___ Car Seat Program ___ Head Start ___ Other Organization_________________________
___ Medical Provider and/or Health System/Clinic ____

Initial Information you agree to release and exchange:

___ All Information that I have provided to the WIC Program, measurements and assessments made by the WIC Program, appointment dates and times, and whether I participate in the WIC program.
___ My participation in the WIC Program, my contact information, and my appointment dates and times.

This information will be used to:

- Contact me to provide information.
- Provide continuity of care with other programs, services, and or providers.
- Provide referrals to services that I am eligible for and wish to participate.

How will my privacy be protected? The information about me is private and protected by federal and state privacy laws. The Minnesota WIC Program will not release identifying information to any unauthorized person without my permission. After the information is disclosed to other public health programs, the information will be protected by the Minnesota Government Data Practices Act. Under that Act, health information about me is private. The staff of the public health programs will have access to the information to the extent needed to perform their job duties for the programs. My medical doctor must protect the privacy of my health information under federal and state privacy laws.

Whether I need to sign? I understand that I do not have to agree to the release of information described in this document. I also understand that refusing to sign this authorization will not affect my eligibility or participation in the WIC Program or any other public health program, will not affect the current or future care I receive from any health care provider, and will not cause any penalty or loss of benefits to which I am otherwise eligible. However, if I do not sign this authorization and participate in more than one program, I may be asked the same health questions or take the same measurements more than once.

Cancelling my permission: I may cancel my permission at any time. In order to cancel my permission, I need to send or deliver a letter to Blue Earth County WIC program, 410 South Fifth Street, PO Box 3526, Mankato, Minnesota, 56002; and include in the letter my request that my permission be cancelled, my name and date of birth, and my signature. This authorization expires five years from the date of my signature, unless it is revoked at an earlier date by me.

_____________________________________ _______________________ _________________________

Signature of Participant, Parent or Guardian **Printed Name** **Date of Signature**