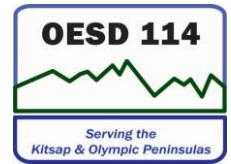




Olympic Educational Service District 114
105 National Avenue North, Bremerton, Washington 98312
(360) 478-6887 • 1-800-201-1300 • FAX (360) 405-5808



Authorization to Exchange Information

Child _____ DOB _____

I hereby authorize Olympic ESD 114 Early Head Start/Head Start/ECEAP Program to exchange confidential information with:

Agency Name	Contact Person
_____	_____

Check all that apply.

- | | |
|---|--|
| <input type="checkbox"/> Education Records | <input type="checkbox"/> Special Education Records |
| <input type="checkbox"/> Health Records | <input type="checkbox"/> Public Health Nurse |
| <input type="checkbox"/> Psychological/Counseling Records | <input type="checkbox"/> Other (Specify) |

Authorization

This authorization is valid for one calendar year. It will expire on _____.
I understand the information obtained will be treated in a confidential manner and will not be transmitted to a third party without my permission. I understand it is my right to request a copy of all information and contest any information I feel is incorrect. I understand that I may revoke the authorization at any time by notifying staff in writing.

Signature _____ Date _____

Print name _____

Relationship to child _____ Program Name _____

