Authorization to Release WIC Information   WIC Participant or Applicant

Name of WIC Participant: ____ ID# _________________ Date of Birth: __________

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Declining to sign this release will not impact your eligibility to participate in the WIC Program and the identifying data will not be shared.

Information that may be released: I give the Minnesota WIC Program my permission to release the following information about my child (children) or myself named above: **Check statement (s) to grant permission:**

______ Lead level screening (which is not a part of the WIC program, but can be completed during your visit)

I give the Minnesota WIC Program my permission to release the information described above to (Please check in blanks below):

_______My child's or my medical doctor, whose name and address are: ____.

How will this information be used?

- The public health programs listed above will use the information:
  1. To determine whether I or my child is eligible to receive services from those programs; and/or
  2. To provide services under those programs if I or my child is eligible and if I or my child wish to participate with the programs.
- My child's or my medical doctor or health care provider may use the information to provide health care to my child or me.

How will my privacy be protected?

- At the WIC Program, the information about my child and me is private and is protected by federal and state privacy law. The Minnesota WIC Program will not release identifying information to any unauthorized person without my permission, or that of another parent or guardian.
- 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 my child and 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 child's and my medical doctor must protect the privacy of 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 refusing to sign this authorization **will not affect** my child's or my participation in the WIC Program or a public health program, or will not affect the current or future care I receive or my child receives from any health care provider, and will not cause any penalty or loss of benefits to which I or my child is otherwise entitled.
- However, I understand if I do not sign the authorization, it may be more time-consuming for Beltrami County Health & Human Services to coordinate public health services for my child or me.

Whether I may cancel 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 Beltrami County H&HS and include in the letter my request that my consent to release information be cancelled, my child's name and date of birth, and my signature.
- This authorization stays in effect for one full year from the date of signature unless rescinded.

Signature of Parent or Guardian: ____ Date: ____________

Name of Parent or Guardian: (printed) ____

Note: The local agency shall provide a copy of this signed release to the parent or guardian. This document complies with the requirements of HIPAA (the Health Insurance Portability and Accountability Act), the Minnesota Government Data Practices Act, Federal WIC regulations, and the Minnesota Medical Records Act. See 45 C.F.R. § 164.508(c) (2002); 7 C.F.R. § 246.26(d) (2002); Minn. Stat. §§ 13.05, subd. 4(d), 144.335, subd. 3a (2002). Adapted for Beltrami County Health & Human Services: 12/28/2010 Rev. 6/16/2014 *USDA is an equal opportunity provider and employer*