SUMMIT HEAD START 0-5

EDUCATION HEALTH SELF SUFFICIENCY COMMUNITY

Consent for the Release of Confidential Information
Summit Head Start 0-5

Child's Name: _____ **Date of Birth:** _____

I _____ (printed name of parent/guardian) authorize the Summit Head Start (HS0-5) Program to 1) include the information I provide on enrollment and assessment paperwork in confidential, secure databases*, 2) share my child's name and DOB with Summit School District in order to track long-term outcomes for HS0-5 participants, and 3) disclose and exchange information about my case with relevant partner staff and the following

HS0-5 Partners—HS0-5 partners with several agencies to deliver program services. It will be necessary for us to share child information to determine enrollment and maintain enrollment with the following:

Early Childhood Options (ECO)
Mili Sarmiento Shoemaker, LPC, RPT-S
Family & Intercultural Resource Center (FIRC)
Summit School District (SSD)
Summit County Preschool
Lake Dillon Preschool
Clayton Early Learning
Results Matter (state ECE initiative)
Breckenridge Tuition Assistance
Building Hope
April Kemp, MHC
- Oliver Behavioral Consultants
-Summit County Government
-Early Intervention Colorado (EI)
-Public Health Nurses
-Women Infants & Children Program (WIC)
-CCCAP (Colorado Child Care Assistance Program)
-Human Services
-Summit County Right Start Project (county ECE initiative)
-Carriage House Childcare
-Mili Sarmiento Shoemaker, LPC, RPT-S
- Mountain Speech and Language Therapy _____Please initial.

Health Tracking—If enrolled, HS0-5 is required to track health information. Please provide names of any additional health providers you work with so we may contact them to share medical information. I authorize the following providers to exchange my medical and dental health information with Summit County Head Start 0-5:

Centura/High Country Healthcare (HCHC)_____ **Dr. Ebert Santos _____** **Pediatric Dental Group____**
Summit County Public Health____ **Summit Community Care Clinic _____** **All Kids Dental P.C.____**

Additional Health Care Providers: _____

Additional Dental Care Providers: _____

Other: _____

Please inform HS0-5 staff if you change primary health providers.

_____Please initial

Additional Support—To support you and your family, we work with many other community partners. Please initial the additional organizations you allow us to share information with.

_____ **Advocates for Victims of Assault**
_____ **Colorado Mountain College (ESL & Family Literacy)**
_____ **Colorado Workforce Center**
_____ **Summit County Child Care Centers/Licensed Child Care Providers**
_____ **Holiday Donation Agencies**
_____ **Nurse Family Partnership**
_____ **Strengthening Families (Y&F)**
_____ **NW Colorado Center for Independence**

*Names of databases given upon request.

I consent and understand that I can revoke my permission to release confidential information at any time. I understand that use of child data may be used for long term studies unless I sign for revocation of consent. I understand that some or all of the above listed agency personnel are required by law to report any suspected abuse and/or neglect.

_____ _____
Parent/Guardian Signature Date

_____ _____
EHS/HS Staff Signature Date

For Revocation of Consent Only

Date: _____

Parent/Guardian Signature: _____

Staff Signature: _____

Last update 1.20.22