CONSENT TO RELEASE PERSONAL INFORMATION

Women, Infants, and Children (WIC) Program

I understand that my choice to sign or not to sign this form will NOT affect my eligibility for or participation in the WIC Program, or the eligibility for or participation in the WIC Program of any children for whom I am legally responsible.

I give my permission to the WIC Program to release personal information for (list participant name(s)):

_____
_____

The information may be released to the following person or agency:

_____
_____

The information that may be released is:

_____
_____

The reason the information may be released is:

_____
_____

I also give my permission to the WIC Program to contact the following health care provider(s) to get information the WIC Program may need to certify my family for WIC services or to verify services needed:

_____	_____	_____
(Provider)	(Phone)	(Address)
_____	_____	_____
(Provider)	(Phone)	(Address)

This agreement to release personal information will begin on _____, and will end on _____ (not to exceed twelve months).
Date Date

I understand that at any time I may submit a written request to the WIC Program to cancel this agreement.

_____	_____	_____
Family Representative	Signature	Date