Nevada State WIC Program
Authorization For Release of Information

Participants Name: _____ Date of Birth: _____

Sponsors Name: _____ Date of Birth: _____

Address: _____ Phone Number: ( ) _____

I herby authorize: _____
Person or Agency

_____
Address/Phone Number

To release to: _____
Person or Agency

_____
Address/Phone Number/Fax Number

The following information:

_____ Certification information only (Certification date, recertification date, category, priority, nutritional risk(s) qualifying the persons for WIC, and benefits received last.)

_____ Growth Charts

_____ Hemoglobin (Iron) Screening

_____ Complete WIC record

_____ Other: _____
(must be specified)

This consent is valid for 180 days from the date listed below and is subject to revocation at any time. The information given or received is confidential. Further disclosure to other persons is strictly forbidden by Federal Law without the specific written consent of the client, with the exception of program or physical audit where such information is kept confidential.

_____ _____ _____
Date Authorized Signature Relationship to Participant(s)

_____ _____
Date Signature of WIC Clinic Official

The requested information specified above was _____ to the stated recipient on _____. _____
(given/mailed/fax) (Date) (Staff Initials)

This authorization form is to be released to the clinic, agency, or person named above. A copy is to be placed in the client's record and a copy provided to client upon request. The Special Supplemental Food Program for Women, Infants, and Children is open to all eligible persons regardless of race, color, disability, gender, age, national origin.