Public Health
Prevent. Promote. Protect.

SHERBURNE COUNTY

Sherburne County WIC Program
Authorization to Release Information

Household ID # _____ **Name_____** **Name_____**
Name_____ **Name_____** **Name_____**

I give my consent to the Sherburne County WIC program to release and exchange all information that I have provided to the WIC program, all measurements and assessments made by the WIC program, and whether I participate in the WIC program with:

(Please INITIAL the program(s) you agree to release and exchange information):

Public Health programs in Sherburne County Health & Human Services:

___ Child & Teen Checkup Outreach
___ Child Passenger Safety
___ Family Home Visiting
___ Follow Along Program
___ Help Me Grow
___ First Steps Central MN

My Medical Provider or Clinic:

___ Clinic: _____ City: _____

___ Clinic: _____ City: _____

___ Other Provider/Organization_____

How this information will be used?

- The programs listed above will use the information to provide service under those programs if I am eligible and wish to participate.
- My Medical Provider will use the information to provide health care to me.

How will my privacy be protected?

- At the WIC Program, the information about me is private and is protected by federal and state privacy law. The Sherburne County WIC program will not release identifying information to any unauthorized person without my permission. WIC program regulations also require my consent to release WIC data to any third parties not listed here.
- The information will be protected by the Minnesota Government Data Practices Act. Under that Act, health information about 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 medical provider must protect the privacy of my health information under federal and state data 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 that refusing to sign this authorization will not affect my eligibility or participation in the WIC program or any other public health program, will not affect the current or future care I receive from any health care provider, and will not cause any penalty or loss of benefits to which I am otherwise eligible.

Cancelling my consent

- I may cancel my consent at any time. In order to cancel my consent, I need to send or deliver a letter to Sherburne County WIC program and include in the letter my request that my consent be cancelled, my name and date of birth, and my signature.
- This authorization expires one year from the date of my signature, unless it is revoked at an earlier date by me.

_____	_____	_____
Date	**Signature of Participant or Parent/Guardian**	**Printed Name**

WIC is an equal opportunity provider