AUTHORIZATION FOR RELEASE OF INFORMATION FROM WIC

I _____authorize the _____WIC Program
(Print Name)

To release the following information: *Please **select yes or no** to indicate if WIC may release the information below*:

- ☐ Yes ☐ No Nutrition Care Plan
- ☐ Yes ☐ No Food/Formula Prescription
- ☐ Yes ☐ No Health Insurance Information
- ☐ Yes ☐ No Height/Length/Weight
- ☐ Yes ☐ No Hemoglobin/Hematocrit/Lead
- ☐ Yes ☐ No Immunizations
- ☐ Yes ☐ No Coordination of Appointments
- ☐ Yes ☐ No Other (MUST be specific): _____

_____

_____

From the WIC record of:

Participant Name: _____ Date of Birth _____/_____/_____

To:

Name of Individual(s) and/or Organization(s): _____

_____

☐ *Please check if WIC may release the above information to MassHealth/Durable Medical Equipment (DME) Provider.*

For the following reason(s):

State the reason(s) for sharing this information. If you do not want to list reasons, simply write, "At my request":

_____

- I understand that the person(s) or organization listed here may not be covered by federal or state privacy laws, and they may be able to further share the information WIC gives them.
- I am requesting that the WIC Program provide the information specified above even though I know that federal law gives me the right to obtain WIC benefits and to keep WIC participant records private. I may refuse to sign this authorization. If I refuse to sign my/my child's WIC eligibility and benefits will not be affected.
- I understand that I can change my mind and cancel this authorization at any time. To do this, I need to write a letter to WIC and send it or bring it to the WIC program where I am now giving this permission. Once the information has already been given out by WIC, I understand that it is too late for me to cancel the authorization.

Participant/Parent/Guardian Signature: _____

Relationship to Participant: _____ **Date:** ____/_____/_____

This authorization is valid for one year from the date of signature.