



Central Council Tlingit and Haida Indian Tribes of Alaska

TLINGIT & HAIDA HEAD START

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ERSEA (Enrollment)

Request to Release & Exchange Information and Notice of Confidentiality

Dear Parents/Guardians:

To provide your family with quality services, it may be necessary to release and exchange information with others that serve your family and child. For example, to review your child's eligibility, Head Start will need income statements from ATAP or TANF. Other examples are to allow Head Start to send immunization records to your child's local school when he/she transitions to kindergarten, or request current immunization, physical or dental exam records from your child's health care providers. Your written consent is required to legally release and exchange information. This Request to Release & Exchange Information form allows us to share this information between programs/agencies.

All information gathered is kept confidential and released only when your permission is given. Parents and legal guardians of Head Start children have the right to access their child(ren)'s files at the Head Start center as well as at the Head Start Central Office located in Juneau, Alaska.

CHILD'S FIRST & LAST NAME:	CHILD'S DATE OF BIRTH:
Alaska Temporary Assistance Program (ATAP) Benefits-Case worker: _____ Temporary Assistance for Needy Families (TANF) Case worker: _____ Supplemental Security Insurance (SSI) Benefits-Case#: _____ State Disabilities Assistance Benefits-Case#: _____ Foster Care-Health & Social Services: _____ Guardianship – Alaska Legal Services: _____	

SEARHC requires a specific Release of Information form to release & exchange information to Head Start. If you are a SEARHC client, please complete a Head Start & SEARHC form in addition to this ROI form.

I request the following information for me or my child to be released and exchanged between Tlingit & Haida Head Start:

PROVIDE CLINIC NAMES (REQUIRED):

Dental Records / Name of Clinic: _____

Medical Records & WIC / Name of Clinic: _____

Immunization & TB Test Records/Name of Clinic: _____

Please fill out if you receive these services for your child:

NAME OF AGENCY (REQUIRED):

Infant Learning Program (ILP) / or Other Program: _____

Developmental Screening and Assessment Information at: _____

Individualized Education Program (IEP or IFSP) from Local Education Agency (LEA): _____

Behavioral or Social/Emotional Service Agency: _____

Individual Learning Plan (ILP) Records from another Pre-K Program: _____

Other (records created during Child Find, Tots Clinic, etc.): _____

This release & exchange of information is valid for 12 months from date signed.

PARENT/GUARDIAN SIGNATURE

PRINTED NAME

DATE