Riverside University HEALTH SYSTEM Public Health

CALIFORNIA WIC WOMEN, INFANTS & CHILDREN

WIC PROGRAM PARTICIPANT
CONSENT TO RELEASE PERSONAL INFORMATION
(OPTIONAL)

I UNDERSTAND THAT MY CHOICE TO SIGN OR NOT TO SIGN THIS FORM WILL NOT AFFECT MY ELIGIBILTY FOR OR PARTICPATION 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 release confidential information I have provided to the WIC Program about myself, or children for whom I am legally responsible, to persons or organizations which administer health and welfare programs, and serve persons eligible for the WIC Program.

I understand that these organizations agree not to release this information to any other State or Federal program, and that the organizations agree to use the information only to determine eligibility for these health welfare programs, and to provide information about services provided by these programs.

This confidential information may include: names, addresses, telephone numbers, and date of birth, Social Security numbers, and certain medical information. The medical information released under authority of this document is restricted to: body weight and length/height, hemoglobin/ hematocrit results, dates of immunizations, expected delivery date, date last pregnancy ended, the number of times pregnant and the number of prior deliveries.

The organizations to which the WIC program may release personal information are:

* Adolescent Family Life Program (AFLP)
* Maternal and Infant Health Assessment Survey
* MCAH-Maternal Child Adolescent Health
* California Children Services (CCS)
* California Birth Defects Monitoring Program
* Child Health and Disability Prevention Program (CHDP)
* Comprehensive Perinatal Services Program (CPSP)
* Office of Family Planning
* Loving Support
* Healthy Families
* Immunization Programs (IZ)
* Cal-Learn Program
* Domestic Violence Program
* Public Health Nursing
* Assistance for Infants and Mothers (AIM)
* Medi-Cal
* Disease Control
* Car Seat Program
* Black Infant Health Program
* CalFresh
* Head Start Program
* Temporary Assistance for Needy Families (TANF)

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 me or my children for WIC services needed:

_____	_____	_____
(Provider)	**(Telephone)**	**(Address)**
_____	_____	_____
(Provider)	**(Telephone)**	**(Address)**

This agreement to release personal information shall be effective for twelve (12) months from the date I signed this form. I understand that I may cancel this agreement at any time by submitting a written cancellation notice.

_____	_____	_____
Name of Participant/ Parent/ Guardian (PRINT)	Signature	Date

WIC is an equal opportunity program. If you believe you have been discriminated against because of race, color, national origin, age, sex or handicap, write immediately to the Secretary of Agriculture, Washington, DC 20250.