Contra Costa County WIC Program
Participant Authorization to Release/Obtain Personal Information
Consent Form

(Optional)

I UNDERSTAND THAT MY CHOICE TO SIGN OR NOT TO SIGN THIS FORM WILL NOT AFFECT MY ELIGIBILITY FOR OR PARTICIPATION IN THE 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/obtain personal information I have provided to the WIC Program about myself, or children for whom I am legally responsible, to the following agencies listed below.

This confidential information may include personal information such as names, addresses, telephone numbers, dates of birth, body weight, body length, 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 REASONS INFORMATION MAY BE RELEASED/OBTAINED ARE:

1. To assist my children and me to benefit from services provided by the agencies listed below.
2. To ensure my children and I are receiving optimal health care.
3. To obtain information the WIC Program may need to certify my family for WIC Program services.
4. To e-mail, text or call me about my WIC appointment and/or services available.

THE ORGANIZATIONS TO/FROM WHICH THE WIC PROGRAM MAY RELEASE/OBTAIN PERSONAL INFORMATION ARE:

- CONTRA COSTA HEALTH SERVICES
- CONTRA COSTA HEALTH PLAN
- CONTRA COSTA REGIONAL MEDICAL CENTER
- CONTRA COSTA COUNTY EMERGENCY MEDICAL SERVICES
- CONTRA COSTA PUBLIC HEALTH (CHDP, PCG, BIH, PH Nursing, CCS, Clinic Services, HFA, CWPP)
- CONTRA COSTA MENTAL HEALTH
- YOUR MEDICAL PROVIDER
- CAL-FRESH
- FOOD BANK OF CONTRA COSTA
- MEDI-CAL PHARMACIES
- HEALTHY START, HEAD START, FIRST 5, PLANNED PARENTHOOD
- PUBLIC HEALTH FOUNDATION
- LOCAL HOSPITALS & NEWBORN CLINICS
- LEGAL AID AT WORK
- OTHER: _____

This agreement to release/obtain personal information shall be effective for twelve 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

I have been offered a copy of the Contra Costa County Notice of Privacy Practices. https://www.cchealth.org/home/showpublisheddocument/7663/638261689667230000

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

WIC IS AN EQUAL OPPORTUNITY PROGRAM.