

(Local Agency Letterhead)

**CONSENT FOR RELEASE OF PARTICIPANT INFORMATION**

**WIC personnel have permission to release the following information:** (a WIC applicant/participant or the parent/guardian may have access to all information provided by the applicant/participant and a medical record which includes WIC forms completed by WIC personnel or health care providers that provide medical/nutrition risk assessment for determination of Program eligibility)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**This information will be provided for the following WIC participant(s):** (give full names)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**This information will be provided to the following person/agency by \_\_\_\_\_:**  
**Date**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**Signature of Person Requesting Information** **Date**

\_\_\_\_\_  
**Signature of WIC Staff/Witness** **Date**

\_\_\_\_\_  
**Signature of WIC Staff Releasing Information** **Date**

\_\_\_\_\_  
**Payee WIC Identification Number**