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 ELIGIBILITY FOR OR PARTICIPATION IN THE WIC PROGRAM, OR THE EBIGIBILITY 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 this health and welfare programs and to provide information about services, provide by these programs.

This confidential information may include: names, addresses, telephone numbers, and dates 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:

- California Children Services (CCS)
- Child Health and Disability Program (CHDP)
- California Birth Defects Monitoring Program (CBDMP)
- California Home Visiting Program
- Domestic Violence Program
- Adolescent Family Life Program (AFLP)
- Comprehensive Perinatal Services Program (CPSP)
- Medi-Cal
- California Home Visiting Program
- Cal-Learn Office
- First Time Parents
- Immunization Program (IZ)
- Office of Family Planning

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 or to verify services needed:

Provider	Telephone	Address
Provider	Telephone	Address

This agreement to release 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	Signature	Date