Westchester County Department of Health
WIC Program
Participant Consent Form

Participant Name: _____ DOB: _____

Health Care Provider (HCP)/Health Center Name: _____

Health Care Provider (HCP)/Health Center Phone Number:_____

I give permission to the Westchester County Department of Health WIC Program to: (check Yes or No)

Communicate with HCP regarding participant health information: ☐ **Yes** ☐ **No**

Share contact information for community health referrals: ☐ **Yes** ☐ **No**

If I refuse or am unable to have these tests done at the WIC Office, I authorize the WIC Program to contact my HCP for the information. I authorize my HCP to release the information above to the WIC Program, and I authorize the WIC Program to release information about me or my child to this health care provider for the purposes of coordinating my or my child's healthcare. If my child or I need to transfer to another WIC Program, I authorize the release of this information to the transferring WIC Program. All information is considered confidential. I understand that I may cancel this permission at any time by submitting a request in writing to the Westchester County Department of Health WIC Program. I understand that this release will not impact my eligibility for participation in the WIC program.

Participant/Guardian Signature: _____ **Date: _____**

Check one: ☐ **Authorized Representative** ☐ **Parent/Spouse/Partner/Caretaker**

WIC Staff Signature: _____**Date: _____**

For staff use only:

WIC ID # _____