

# Breaking the Barriers to Child Care Scholarship Program

I, \_\_\_\_\_, hereby authorize  
(parent's or guardian's name)

Livingston County Community Coordinated Child Care (4C) Council to release information contained in the records of \_\_\_\_\_, birth date \_\_\_\_/\_\_\_\_/\_\_\_\_, social security # \_\_\_\_\_ to the program or organization listed below.

1. Name of program or organization to whom information is to be released:

Great Start Michigan and Livingston Collaborative and Great Parent Great Start Program  
1425 West Grand River  
Howell, MI 48843

2. Specific type of information to be disclosed: Child's name, birth date and place of birth

Name: \_\_\_\_\_

City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_

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3. The purpose and/or need for such disclosure: *(Please initial each category requested)*

( ) coordination of services

( ) other: \_\_\_\_\_

4. The date (not to exceed one year), event, or condition of expiration, unless revoked by me in writing prior to that date or event: \_\_\_\_\_

5. My signature indicates that I am aware that I have the right to know exactly what information is being disclosed. I have read this form and/or have had it explained to me in language I can understand. A copy of this form will suffice in the place of an original.

I understand that I may withdraw this consent (in writing) at any time except to the extent that the agency or the persons who work here have already taken action in reliance upon it. It is valid only for the purpose, information, and agencies, and persons listed above.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Signature date

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
\*Witnessed by date

\*Witness assures person is competent to give informed consent.