

Data Privacy Notice and Consent for Infant

Why are we giving you this form to sign?

As part of your participation in the Twin Cities Healthy Start program at [site name], we collect some information about your infant. Federal and state laws provide your child certain privacy protections for that information. [site name] and the Minneapolis Department of Health and Family Support are required to give you notice regarding the privacy of your child's data and to keep some evidence that the notice was given. Also, [site name] is requesting your consent before your data can be shared with the Minneapolis Department of Health and Family Support.

What information do we want?

We will ask you about the outcome of your pregnancy, and your baby's birth date, birth weight, name, and gender. We will also ask whether your baby is covered by health insurance, the type of coverage (such as Medicaid or private), and what clinic you use for your baby's health care. We will also ask the date of your first well-baby visit.

Private information is protected by federal and state laws. You are not required to answer the questions asked, but this information helps us and staff members from the Minneapolis Department of Health and Family Support evaluate the services we provide through the Twin Cities Healthy Start program. The staff at the Minneapolis Department of Health and Family Support are required by law to keep all health data private.

We request that you sign below to acknowledge that we gave you this information:

If you wish to sign this form, that is the best way for us to document that we gave you this notice. If you don't wish to sign the form, we will have someone else attest that we gave you this information.

I have read (or had read to me) the above disclosure and understand the uses for the private information I am providing for my baby. I have also received a copy of this disclosure.

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|--|---------------------------|
| | |
| <i>Mother's name (Print)</i> | <i>Mother's signature</i> |
| | |
| <i>Baby's name(s)</i> | <i>Date</i> |
| | |
| <i>Staff reading the disclosure (if necessary)</i> | <i>Date</i> |

We request that you sign below to give us your authorization to share your baby's data with the Minneapolis Department of Health and Family Support

You can provide that authorization by signing below. Your consent will be valid for two years unless you choose to withdraw consent before that time.

I have read (or had read to me) the above disclosure and authorize [site name] to share my data with the Minneapolis Department of Health and Family Support. I understand my consent for my baby's information will be valid for 2 years from today's date unless I later withdraw my consent.

| | |
|---------------------------|-------------|
| | |
| <i>Mother's signature</i> | <i>Date</i> |