

APPENDIX W.1

AGE 3 EXTENSION WIC INFANT AND TODDLER FEEDING PRACTICES STUDY - II  
HIPAA LETTER/FORM - ENGLISH



DATE

NAME

ADDRESS

Dear <Caregiver First Name>,

We are happy to have you and <Child's first name> as part of the WIC **Feeding My Baby** study. Your voluntary participation is important in helping America learn about the choices WIC families make in feeding their children.

We would like your permission to get the height and weight of <child's first name> from your child's doctor.

Please return one signed copy of the Medical Release form in the postage paid envelope. Upon receipt of your form, we will put \$20 on your Payoneer Card as a token of our appreciation. If you have any questions, please contact your Study Liaison, <Study Liaison Name> at <toll free number>.

Best wishes,

The Feeding My Baby Study Team

STATE SITE#

**Permission to Get Height and Weight Information from Medical Records - English**  
**WIC Feeding My Baby Study**  
**Food and Nutrition Service, U.S. Department of Agriculture**

If you sign this document, you are giving permission to your child's doctor to release health information that identifies you to Food and Nutrition Service (FNS) and Westat for the WIC Feeding My Baby Study. The health information that we will use for the Feeding My Baby Study includes **your child's weight and length from your child's doctor up until your child is 3½ years old**. We will use this health information, along with information you give during your interviews and information from your WIC records, to learn more about the health and feeding choices of WIC families.

Your child's doctors are required by law to protect your health information. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) prevents them from releasing your health information without your permission. Once your information is released to us it is no longer protected by HIPAA, but the same privacy protections FNS and Westat takes with your other information will also apply to your child's medical records. Your name and your child's name will not be used in any research reports, and we will not share personal information about you with WIC or with anyone else who is not on the study staff, except as required by law.

Your child's doctor may not refuse to treat you because of your decision to sign or not sign this authorization. You can change your mind and take back this authorization at any time by contacting the Feeding My Baby study by phone at 1-888-452-2083 or in writing at Westat, 1600 Research Blvd., Rockville, MD 20850, Attn: Bryan Williams, RW2653. The Feeding My Baby study would not seek any more records about you or your child, but would still use any records that had already been released.

By signing this document, you are authorizing your child's doctor to release information on your child's height and weight to Westat for this research. The permission is only for the study period of May 15, 2013 to December 31, 2018.

*I am voluntarily giving permission for my child's height and weight medical records, as described above, to be released to Westat for the Feeding My Baby Study.*

**Patient's Name (Child):** \_\_\_\_\_  
Please Print Your Child's Full Name

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Month Day Year

**Parent or Guardian Signature for Child:** \_\_\_\_\_

Signer's Relationship to Child: \_\_\_\_\_

Date Signed: \_\_\_\_\_