

Authorization for Release of Information

I. _____ give Permission for
(Parent or legal guardian)

(Profession/facility)

To release to _____ the following information
(Child Care program)

(Screenings, test, diagnoses, and treatment, or recommendations)

The information will be used to plan and coordinate the care of my child and will be kept confidential and may only be shared with _____
(Staff title/name)

Name of
Child: _____

Address: _____

City: _____ State _____ Zip Code: _____

Date of Birth: _____

Parent/Legal Guardian Signature

Date

Witness Signature

Date

Staff member to be contacted for additional information