

## Authorization for Release of Information

I, \_\_\_\_\_ give permission for  
(parent or legal guardian)

\_\_\_\_\_  
(professional/facility)

to release to \_\_\_\_\_ the following information  
(child care program)

\_\_\_\_\_  
(screenings, tests, diagnoses and treatment, or recommendations)

The information will be used solely to plan and coordinate the care of my child and will be kept confidential and may only be shared with

\_\_\_\_\_  
(staff titles/names)

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

From: American Academy of Pediatrics, PA Chapter, (2002) Model Child Care Health Policies, 4th