



Authorization of Release of Information

Prepared by the Health Consultant Team at Child Care Aware® of North Dakota

Name of child: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

I, _____ hereby give permission for
(name of legal guardian)

_____ (professional / facility)

to release _____
(screenings, tests, diagnoses and treatment, or recommendations)

for the child named above to _____
(child care program)

This information will be used solely to plan and coordinate the care of the child named above. This information will be kept confidential and only shared with:

_____ (staff titles / names)

Signatures:

_____ (Signature of Parent/Guardian)

_____ (Date of signature)

_____ (Signature of Witness)

_____ (Date of signature)

Contact for additional information:

Name of contact: _____

Phone: _____ Email: _____

Address: _____

City: _____ State: _____ Zip Code: _____

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

Revised 7/15