Authorization of Release of Information

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)

Form provided by Child Care Aware® of North Dakota Health Consultants.

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