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