

# Authorization of Release of Information

Name of child: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

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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)

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## 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.  
Revised 8/19  
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