Release of Information Permission

I authorize Beautiful Minds Child Care to submit the state required forms to my child's health provider for their signature to comply with licensing regulations for childcare. I agree that the forms can be mailed back to the center at 2821 Fairfax Street Eau Claire, WI 54701.

Child's Name______________________________

Date of Birth_______________________________

Name of Health Care Provider______________________

Name of Clinic_________________________________

Address of Clinic_________________________________

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- Information to be released Physical and Immunization records.
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- This authorization will terminate in one year unless otherwise specified:_____________________.
- This authorization may be revoked at any time by providing a written notice of revocation to Beautiful Minds Child Care, except to the extent that the providers listed above have already taken action in releasing the information.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Federal Privacy rules.
- I authorize the release of medical information created after the date of my signature.

Signed: ________________________________

(parent or guardian)

Date: _______________________