AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Child's Name: _____ Date of Birth: _____

Previous Name: _____ _____

I request and authorize _____ to

release healthcare information of the patient named above to:

Name: Whiz Kids Learning Center

Address: 593 Flint Street

City: Marstons Mills State: MA Zip Code: 02648

Phone: (508) 428-0188 Fax: (508) 419-7444 _____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: Current Physical, Immunization Records, Mental Health Records, Medication Records, Allergy Records and Developmental History/Issues and Lead Paint Screenings

_____

Physicians Office:_____

Address:_____

City, State, Zip Code:_____

Phone #:_____

Fax#:_____

Parent/Guardian Signature: _____ Date Signed: _____

Print Parent/Guardian's Name:_____