Authorization for Release of Information

I, ____ give permission for

parent or legal guardian

____

professional / facility

to release to St. Ambrose University Children's Campus **the following information**

____

screenings, tests, diagnosis and treatment, or recommendations

The information will be used solely to plan and coordinate the care of my child and will be kept confidential and may only be shared with

____

staff title / name

Name of Child ____

Address ____

City ____________________________________ **State** ________________ **Zip Code** ___________

Date of Birth ____________________________________

____

Parent / Legal Guardian Signature **Date**

____

Witness Signature **Date**

____

Staff member to be contacted for additional information **Phone**

1/05

St. Ambrose University Children's Campus
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