



Authorization is given to The Learning Center for Families for the following party:

Name: _____

Address: _____

To exchange information necessary for determining eligibility, planning and coordinating services for:

Name: _____ D.O.B _____

I understand that I may revoke this request in writing anytime. All information received will be kept confidential and will be used for professional purposes only.

Signature _____ Date _____

Request for Information

I authorize the *requesting* of any and all of the following records:

- | | |
|--------------------------------------|---------------------------|
| _____ Service Plan | _____ Vision Report |
| _____ Medical Reports | _____ Hearing Report |
| _____ CHECK or Well Baby Examination | _____ Birth History |
| _____ Immunization Record | _____ Dental Records |
| _____ Ht/Wt/OFC | _____ General Information |
| _____ Hgb/Hct | _____ Other: _____ |

Release of Information

I authorize the *release and sharing* of any and all of the following records/information with appropriate health care providers:

- | | |
|--|---|
| _____ Service Plans | _____ Health Screen |
| _____ Developmental Assessments | _____ Child Health and Demographic Information |
| _____ Social-Emotional Assessments | _____ General Information |
| _____ Motor Evaluations | _____ Other _____ |
| _____ Speech Evaluations | |