AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Child's Name _____

Date of Birth _____

I authorize the use or disclosure of the above named individual's health information as described below: _____

Physician's Name

Physician's Phone: _____ Fax: _____

The type of information to be used or disclosed is as follows: (please check below)

☐ Physical Exam Report ☐ Immunization Report ☐ Complete Medical Record

☐ Permission to administer medication in daycare, including diagnosis

☐ Other _____

The information identified above may be used or disclosed to my daycare provider:

CHILDREN'S SAFE STAY, INC
PO BOX 152
SPARROWBUSH NY 12780
845-858-4923 Fax 845-858-8686

The information for which I'm authorizing disclosure will be used for proof of immunization, annual physical information, or permission to administer medication.

Unless I specify differently, this authorization will expire: _____
I understand that I have a right to revoke this authorization in writing at any time; I must do so in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization.
I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

PLEASE FAX AS SOON AS POSSIBLE AND MAIL ORIGINAL TO ABOVE ADDRESS.

Signature of legal representative: _____

Date: _____ Relationship to patient _____