

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: _____

