CENTRAL FAITH CHILD DEVELOPMENT CENTER AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize the following information to be released from the medical records of :

CHILD'S NAME:______________________________________ D.O.B. :________________________

ADDRESS:____________________________________CITY:______________STATE:________ZIP:________

TELEPHONE:_________________________

This information is to be released to :

Central Faith Child Development Center, Inc.
5720 Bagby Ave.
Waco, TX 76712
254-420-2931
254-420-4903 fax

FROM:____

____

CITY:______________STATE:___________ZIP:________

CHECK THE APPROPRIATE:

*SHOT RECORDS____________

*DOCTOR STATEMENT_____________
Statement that verifies shots are current and the child has been seen within a year and are clear to attend a childcare facility.

Purpose of Disclosure:

*****BOTH OF THESE ARE REQUIRED BY CHILDCARE LICENSING IN THE STATE OF TEXAS TO BE IN A CHILD'S FILES AND MUST BE SUBMITTED BY THE FIRST DAY OF ATTENDANCE.**

I understand that to the extent any Recipient of this information, as identified above, is not a "covered entity" under Federal or Texas Privacy law, the information may no longer be protected by Federal and Texas Privacy law once it is disclosed to the Recipient and, therefore, may be subject to re-disclosure by the Recipient.

I understand that I may revoke this authorization in writing at any time except to the extent that Central Faith Child Development Center has already relied on this authorization. I understand that I may revoke this authorization by providing Central Faith Child Development Center a written request for revocation stating my intent to revoke authorization.

I understand that Central Faith Child Development Center may not condition treatment on my completion of this authorization form.

If information is being released directly to me, I understand that my medical records may contain reports, test results and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information that has been written in the record. I will not hold Central Faith Child Development Center liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.
This authorization will expire in 180 days upon enrollment.

I understand that the information released is for the specific purpose stated above and may not be provided in whole or in part to any other agency, organization, or person.

____
Signature of Parent or Legal Guardian

____
Date

THE STATE OF TEXAS
COUNTY OF McLennan
Subscribed and sworn (affirmed) before me this date the___________day of ____________ 20_____

____
NOTARY PUBLIC