Kids R Kids North Peachtree City
10 Lexington Pass
Peachtree City, Georgia 30269
Phone: 770-631-3555
Fax: 770-631-0585

Notice/Authorization To Release Information

Date: _____

I hereby authorize:_____
_____
_____
_____

To release confidential records for: _____Birthdate: _____

To: _____
_____
_____

Attn:_____

Information to be released (define in detail): _____
_____
_____

It is understood that the party to whom this information is released will not release it to a third party without appropriate consent.

Records to be Released

__ Consent Forms
__ Psychological Evaluation
__ Special Education Staffing/Minutes
__ Other: _____
__ Medical Records*
__ Medical Form
__ I.E.P. Annual Review
__ Hearing and Vision Report

Reason(s) for Release

__ Educational Planning Purposes
__ Eligibility Consideration
__ Observe and/or deliver service

*The reason for release of medical information and records is to develop a health care plan for the child during the school day. This health care plan will be shared with the parent/guardian/surrogate, child's teachers and the schools clinical staff.

This release of information is valid as long as the student is actively enrolled at Kids R Kids North Peachtree City

I understand that as of April 24, 2003 under the Health Insurance Portability and Accountability Act ("HIPPA") disclosure of certain medical information is limited. However, I expressly authorize disclosure of information so that my child's medical needs may be served while in attendance in Kids R Kids.

I have read this form and agree by signature below.

Signature of Parent/Guardian/Surrogate: _____

Date:_____