# Authorization to Disclose and Receive Medical Records

I _____, provide my authorization to Bend Preschool to discuss my child/ren _____ medical condition with my child/ren physicians and their authorized staff, emergency medical staff, with government agencies as required by law. I also authorize Bend Preschool to release a copy of my child's medical information to those same parties and to receive the same.

Child's Name: _____

Guardian's Name: _____

Guardian's Address: _____

Guardian's Phone Number During the Hours of School: _____

The information is limited and will be used only for the following purpose(s): In the event of injury and emergency care; to discuss a child's illness so that Bend Preschool can determine the health of the child and continued care with Bend Preschool; to ensure that other children are not made ill by an illness of the child named above; and to comply with the required government rules and regulations.

The information is limited and pertains only to medical conditions that pertain to the health of the child while under the care of Bend Preschool and it's staff.

By signing I agree to authorize Bend Preschool and it's staff to discuss this information with the parties noted above and to receive/release medical information regarding the child's health condition. This authorization may be revoked at any time. The only exception is when the action has been taken in reliance on the authorization.

Signature:_____ Date: _____

Signature: _____ Date: _____