AUTHORIZATION TO OBTAIN OR DISCLOSE INFORMATION

Child's Name_____ Adult Representative: _____

Child's Date of Birth: _____ I am the ___ PARENT ___ GUARDIAN ___ CONSERVATOR ___ DESIGNEE

and hereby authorize: **Magical Adventures Learning Center LLC**, located at: **57 Hwy. T Foristell MO 63348**

to obtain or disclose information for the above-named child.

- ☐ Physician and other medical providers for the purpose of medical records, including but not limited to, diagnosis, assessments, lab results, and prescription information.
- ☐ Wright City, Wentzville, Warrenton **(please circle a district)** School District and all its affiliates for the purpose of school records, including but not limited to, state assessments, benchmark assessments, IEP, grades, and curriculum.
- ☐ Specialty Providers, such as, but not limited to, First Steps, Parents As Teachers, United Services, PT, OT, & Speech therapists, etc.

Restrictions: I understand that the recipient of this information may not use or disclose this information except for the express purpose identified above, unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

Notice: Unless specified below, this authorization is for full disclosure of all records, including clinical findings, diagnosis, treatment, assessment, recommendations for further care, names of all health care personnel, dates of hospitalizations and ambulatory visits, charges, and any information that may be related to drug, alcohol, psychiatric conditions, and/or sexually transmitted disease, including AIDS information.

I understand that this consent is only for the specific purpose stated and may be revoked at any time at my written request.

Parent/Guardian Signature: _____ Date: _____

Print Name here: _____ Relationship: _____

A photocopy of this release is as valid as the original.