AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I. I hereby request and authorize the Children's Network of Southwest Florida acting on behalf of the Department of Children and Families, P.O. Box 60085, Fort Myers, Florida 33906.

II. To obtain from ____
(Name of Person or Agency Holding the Information)

____
(Address)

III. The following Information:

____ All Medical Information & Reports
____ Immunizations
____ Prenatal Medical Record
____ X-ray Report(s)
____ Physical examination Report(s)
____ Medical date for WIC Certification
____ Laboratory Report(s)
____ Other (Specify) ____________________

IV. From the medical record of ____
(Print or type name of client, birth date and file number if applicable)

V. For the purpose of ____

VI. **All information I hereby authorize to be obtained from this agency will be held strictly confidential and cannot be released by the recipient without written consent.**
I understand that this authorization will remain in effect during the licensure as a foster home.

VII. **I understand that I may withdraw this consent at any time.**

______________________________ Date
______________________________ Signature of Client or Legal Representative

______________________________ Date
______________________________ Legal Representative's Relationship to Client

---

VIII. **USE THIS SPACE ONLY IF CLIENT WITHDRAWS CONSENT**

______________________________ Date Consent Revoked by Client
______________________________ Signature of Client