bridges
Child Enrichment Center
313 South State Street, Appleton, WI 54911

PARENTAL CONSENT
FOR RELEASE OF
INDIVIDUAL INFORMATION RECORDS

I hereby give my consent for _____
(Physician and Medical Facility Names)
and Bridges Child Enrichment Center staff to exchange / release physical exam and immunization information and / or records concerning my child,

_____.
(Child's Name)

I understand that all information shared about my child will be kept in complete confidence and will not be released to any person or agency other than those directly involved, without my expressed written consent.

****This authorization is valid only while the child is actively enrolled at Bridges CEC. A copy of this form is as effective as the original.**

_____ _____
Parent Signature Date