



AUTHORIZATION FOR RELEASE OF HEALTH AND MEDICAL INFORMATION FOR PROSPECTIVE FOSTER PARENTS

I hereby request and authorize: Kids Central Inc.
2117 SW HWY 484
Ocala, FL, 34473

II. To obtain from: _____
(Name of Person/Agency Holding the Information)

III. The following Information:

All Medical Information & Reports Immunizations
 Prenatal Medical Record X-ray Report(s)
 Physical Examination Report(s) Medical data for WIC Certification
 Laboratory Report(s) HIV Test Results
 Other (specify): _____

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

V. For the purpose of assessing the health of the prospective caretaker as it relates to the applicant's ability to provide long-term care of a child(ren).

VI. I understand that my signature authorizes full disclosure of my medical and health condition and, thereby, includes HIV test results.

VII. All information I hereby authorize to be obtained from this agency will be held strictly confidential and cannot be released by the recipient without my written consent, except for the purpose of judicial review in adoption proceedings. I understand that this authorization will remain in effect during the licensure as a foster home.

VIII. I understand that I may withdraw my consent at any time, but to do so will stop further consideration of myself as an adoptive or foster parent.

Date Signature of Client or Legal Representative

Date Legal Representative's Relationship to Client

IX. USE THIS SPACE ONLY IF CLIENT WITHDRAWS CONSENT

Date Consent Revoked by Client Signature of Client
CF-FSP 5230, PDF 10/2005