EMERGENCY MEDICAL AUTHORIZATION

I, _____ as the parent/guardian of _____ do hereby authorize and grant permission for _____ to secure and obtain such medical treatment and/or care as might be necessary for the above named child under the supervision of said daycare provider. I further authorize said daycare to administer emergency medical care and/or treatment as required until the services of a medical professional can be secured. I agree to pay all costs and fees contingent upon any medical assistance that is rendered as authorized under this consent. I further request that said daycare provider immediately notify me in the case of emergency. _____ assumes no responsibility for any injury or damages, which might result out or in connection with such authorized emergency medical treatment. I am providing the following information regarding the above-mentioned child to use in the event of an emergency:

Name of Child _____
Address _____
Home Phone Number _____
Mother's Work Number _____
Father's Work Number _____
Allergies/medical conditions _____
Family physician _____
Address _____
Phone Number _____
Emergency Contact Name _____
Address _____
Phone Number _____
Relationship to child _____
Medical Insurance Information:
Name of Company _____
Name of Member _____
Policy Number _____
Group Number _____
Phone Number _____

HIPAA Release Authority. My agent shall be treated as I would be with respect to my rights regarding the use and disclosure of my child's individually identifiable health information or other medical records. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. 1320d and 45 CFR 160 through 164. I authorize any physician, health care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy, or other covered health care provider, any insurance company, and the Medical Information Bureau, Inc. or other health care clearinghouse that has provided treatment or services to my child, or that has paid for or is seeking payment from me for such services, to give, disclose and release to my agent, without restriction, all of my child's individually identifiable health information and medical records regarding any past, present or future medical or mental health condition, including all information relating to the diagnosis of HIV/AIDS, sexually transmitted diseases, mental illness, and drug or alcohol abuse. The authority given my agent shall supersede any other agreement that I may have made with my child's health care providers to restrict access to or disclosure of my child's individually identifiable health information. The authority given my agent has no expiration date and shall expire only in the event that I revoke the authority in writing and deliver it to my child's health care provider.

Mother's Signature: _____ Date: _____

Father's Signature: _____ Date: _____