THE STARTING POINT LEARNING CENTER
614.491.1914
2533 Lockbourne Rd Columbus, Ohio 43207-2170
www.startingpointlearningcenter.org

Authorization to Release Information

Parent Name/Legal Guardian:	**Phone Number:**
Child Name:	**D.O.B.:**

I hereby authorize Starting Point Learning Center to

___ Obtain from the following
___ Release to the following

Name:	**Phone:**
Address:	**Fax:**
City/State/Zip:	**Email:**

The documents to be released are described or listed as: Dental Exam

The records are required for the specific purpose of: Child Care

I understand that my authorization will remain in effect for one year and that the information will be handled confidentially in compliance with all applicable federal laws.

I understand that I may see the information that is to be sent, and that I may revoke the authorization at any time by written, dated communication.
I have read and understand the nature of this release.

_____

Signature of Parent/Legal Guardian Date

_____

Signature of Witness Date