



Mercy HealthPlex  
513-942-7539  
mercyhealthplex.com

# KidTown Consent for Release of Information from children’s area program to other individuals/programs

I understand that information regarding my child is generally confidential and may not be given to employees outside the **Mercy HealthPlex** (the “Center”) Kidtown Program without my consent or other legal requirements.

## CONSENT FOR RELEASE OF INFORMATION

I, \_\_\_\_\_, hereby consent to the release of the following information  
Full Name of Parent / Guardian  
initialed and checked below, regarding my child \_\_\_\_\_ held by  
Full Name of Child  
\_\_\_\_\_ to program staff assigned to care for my child.  
KidTown Supervisor or Designated Staff

## PLEASE INITIAL

\_\_\_\_\_ Health History Forms (details of services/accommodations required)

## CONSENT FOR SHARING INFORMATION

I also authorize communication and exchange of information between KidTown Program Staff and other staff on duty. Further, the KidTown Program Staff is authorized to share the information gained with his/her supervisor(s) and/or Center staff working directly with her/him and/or team members with managerial oversight responsibility for the center. Consent for release of information and authorization of communication shall be for the limited purpose of understanding and addressing my child’s needs and customizing my child’s care. This consent is voluntary and I understand that I can withdraw my consent for my child at any time. Unless I withdraw this consent, this consent will be effective for the period my child is continuously enrolled in the KidTown Program. By signing below, I am confirming that I have read, understood and agree to the above.

Name \_\_\_\_\_ Signature \_\_\_\_\_  
Parent / Guardian - Print Full Name Parent / Guardian Signature

Date \_\_\_\_\_