Rainbow Kids
ACHIEVEMENT CENTER
30252 Tomas Suite 100, Rancho Santa Margarita, CA 92688 Ph: 949-459-1658 Fax: 949-459-1667

# Authorization to Release and Request Information

Child's name: _____ DOB: _____

In consideration of my participation in this program, I hereby authorize Rainbow Kids Achievement Center to release information and data relative to the participation of my child and myself in the infant-toddler intervention program and/or individual designated therapy and/or early intervention program. I understand that this information will include such items as goals and objectives released only upon the formal request of a concerned community agency (i.e., Regional Center, Insurance, and School Programs). I further authorize Rainbow Kids Achievement Center to request records from concerned community agencies, physicians, insurance companies and prior developmental and/or therapeutic programs.

I hereby authorize Rainbow Kids Achievement Center to release medical, developmental and/or educational information to my private insurance carrier as is required for determination of benefits. I authorize the release of any medical, developmental and/or educational information necessary to process medical claim. I also request payment of benefits to Rainbow Kids Achievement Center.

This authorization will stay in effect until revoked by me.

I have read and understand Rainbow Kids Achievement Center's Authorization to Release and Request Information Policy.

_____ _____
Parent Signature Date