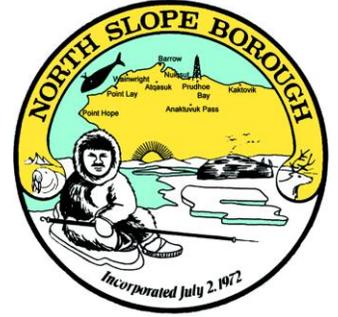


**NORTH SLOPE BOROUGH**  
**DEPARTMENT HEALTH & SOCIAL SERVICES**  
**Barrow Early Learning Center**  
P.O. Box 69  
Barrow, Alaska 99723

Phone:(907) 852-0340  
Fax:(907) 852-0386

**Doreen Leavitt, RN, Director**



**Release of Information**

Childs Legal Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Phone: \_\_\_\_\_

City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

I, \_\_\_\_\_, hereby authorize the NSB Barrow Early Learning Center to release or exchange information for my child with:

Organization: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax: \_\_\_\_\_

I understand that I may revoke this authorization, in writing, submitted at any time to the NSB Barrow Early Learning Center, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will terminate one year from the date of my signature.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Printed Name