City of Center

Police Department

JUVENILE MEDICAL RECORDS RELEASE AUTHORIZATION

Date: Case Number:

ATTENTION: Physicians, Nurses, Hospitals and Medical Facilities at which medical care provisions were received:

By this authorization or a copy hereof, I _____, the parent/legal

Guardian of _____ authorize you to release to any officer of

The Center Police Department and/or the office of the Ralls County Prosecutor, for

Inspection, recording, copying, all medical records, reports, statements in reference to an

Incident occurring on: _____ (date) at _____ (location) involving

_____ (patient) DOB _____. This written permission is

Being given voluntarily and without threats or promises of any kind on

_____ (date) at _____ (time).

_____
Authorizing Signature

Witness: _____

Witness: _____

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