AUTHORIZATION FOR RELEASE OF INFORMATION

INDIVIDUAL SUBMITTING THE AUTHORIZATION PARENT/GUARDIAN OF STUDENT

Last Name: _____ First Name: _____ MI: ____

Street Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Student Name: _____ Student Date of Birth: ____/___/_____

PERSON AUTHORIZED TO DISCLOSE MEDICATION/TREATMENT (INCLUDING IMMUNIZATIONS) RECORDS

Provider Name: _____

Name and Title of individual disclosing information: _____

Address: _____

Phone Number: _____

PERSON AUTHORIZED TO RECEIVE MEDICATION/TREATMENT (INCLUDING IMMUNIZATIONS) RECORDS:

_____

School Nurse or Other Individual – (please use job title not personal name)

Signature for Authorization:

I, _____, authorize the disclosure of medication/treatment information records
(Name of Parent/Guardian)
for the above named student in order to develop an appropriate school day plan of care.

I understand that I may revoke this authorization at any time by giving written notice of my revocation to my provider. In order to obtain a revocation form to revoke this authorization, I understand that I may contact my provider's office. I understand that revocation of this authorization will not affect any action that those named or unnamed herein, took in reliance this information before my provider received my written notice of revocation.

This authorization expires on _____/_____/_____ (no later than end of school year).

Signature (parent or guardian): _____ Date: _____