AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____

Date of Birth: _____ Phone: _____

Address: _____

City: _____ State: _____ ZIP: _____

I authorize _____to release medical information to:
(Physician's Name)

School Name: _____

School Address: _____

_____

School Phone: _____

School Fax: _____

EXPIRATION: Without my written revocation, this authorization will automatically expire upon satisfaction of the need for disclosure, but in any event will expire 180 days from the date hereof, unless otherwise specified: _____

Parent Name: _____
(Please Print)

Signature of Parent: _____

Date: _____