MEDICAL RELEASE OF INFORMATION

This form will authorize the exchange of information between the student's health care provider and school professionals as it relates to the diagnosis/condition listed.

Release of Information	Student Name: First, Middle, Last	Date of Birth:	Phone Number:
	Street Address:	City:	State:
	I, the undersigned, authorize the release of information relating to the diagnosis/condition listed below regarding the above-named student to his/her school principal or school nurse and appropriate school personnel and authorize the school to release and discuss information and reports with the named physician and/or his/her assigned office personnel.		
	Parent/Guardian Signature: Date		

Physician Contact Information	Physician Name:	Phone Number:	Fax Number:
	Office/Practice Name:		
	Address:		

Condition	Student's Diagnosis/Condition:

School Information	School:	Phone Number:
	Contact Person:	Position:
	Address:	