PriMED PHYSICIANS
Treating You Well.®

Authorization for Release of Student Medical Information

Patient Information				
	Last Name First Name Middle			Birthdate
	Address	City	State	Zip
	Daycare/School Attending		Grade	

I hereby authorize PriMED Physicians to release and/or receive medical information from the school listed above by phone or via facsimile. This authorization may include release of information concerning my child including disclosure of medical diagnosis, medication, test results and his/her educational and behavioral management needs.

I understand that this authorization shall remain in effect from July 31, 20__ to August 1, 20__, unless an earlier expiration date is specified in this space (_____). I also understand that I may withdraw this authorization at any time by written notification to the practice. However, this written notification cannot affect actions that have taken place based on my prior authorization.

I understand that if the person or entity that received the above information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

Signature of parent/guardian _____Date_____