

Date: [Date]

To: [Name of Medical Provider/Clinic]

Address: [Provider Address]

Phone/Fax: [Provider Contact Information]

RE: Authorization for Release of Medical Records

Patient Name: [Student Full Name]

Date of Birth: [Student Date of Birth]

Student ID Number: [Student ID, if applicable]

To Whom It May Concern,

I, [Parent/Guardian Name], hereby authorize [Name of Medical Provider] to release the medical records and health information of the above-named student to the administration of [Name of School].

The specific information to be released includes:

[List specific records, e.g., Immunization records, physical exam results, allergy actions plans, or All Records]

Purpose of Disclosure:

[e.g., School enrollment, sports participation eligibility, or health accommodation planning]

Authorized School Representative:

Name: [Name of School Official/Nurse]

Title: [Title]

School Name: [Name of School]

Address: [School Address]

Phone/Fax: [School Contact Info]

This authorization is valid until [Date] or until the end of the current school year. I understand that I have the right to revoke this authorization in writing at any time, except to the extent that action has already been taken.

Thank you for your assistance.

Sincerely,

Signature of Parent/Legal Guardian

Printed Name: [Parent/Guardian Name]

Relationship to Student: [e.g., Mother, Father, Legal Guardian]

Phone Number: [Your Phone Number]