Authorization for Release of Medical Information to School/Daycare

I,_____, parent or legal guardian of:

Child Name:_____

Date of Birth:_____

hereby attest that my child attends/will be attending:

_____
(name of school or daycare)

_____
(phone number)

_____
(fax number)

By my signature below, I hereby allow Pediatrics by the Sea to send any and all information from my child's medical record to the above named school.

The question of privacy between the physicians at the sending facility and my child(ren) is(are) waived. I fully understand that my child(ren)'s medical record or information maintained in connection with the date(s) of service may contain mental health, alcohol, and drug abuse, Human Immunodeficiency Virus (HIV) test results or Acquired Immunodeficiency Syndrome (AIDS) information. The medical records or information authorized to be disclosed by this release are privileged and confidential and may be disclosed only on my, or another legal guardian's authorization, except as required by law. Only such information believed to be necessary for the purpose expressed shall be released and disclosed. I may inspect and arrange for photocopies of the records that are disclosed. If another legal guardian, or I, refuses to sign this authorization, my child(ren)'s records will not be released.

This authorization is valid for one year from the signed date. I may revoke this authorization at any time (except to the extent that action has already been taken in good faith reliance on this authorization) by submitting a written revocation request to the releasing agency.

Parent/Guardian Signature_____ Relationship:_____

Printed name:_____ Date:_____

Witness's Signature: _____ Date:_____