AUTHORIZATION TO RELEASE MEDICAL INFORMATION

TO: **Medical Provider**

I hereby authorize you to release copies of all medical information in your possession, whether paper or electronic, relating to student health review/exams of the student identified below to the school or school district in which the student is enrolled and to appropriate health care providers.

Name of school or school district

This release authorizes disclosure of this information to the school for purposes of the school's determining the fitness of the student to participate in strenuous physical activities, including but not limited to competitive athletic events.

I understand that the medical information disclosed by the medical provider to the school may be further disclosed by the school to the school's administrators, athletic director and coaches of any interscholastic activities in which I seek to participate.

I understand that once the information is disclosed, it may be re-disclosed by the recipient and federal law may not protect the information.

I understand that I may revoke this authorization in writing at any time, except to the extent action has been taken in reliance on this authorization.

I certify that the signatures on this release are voluntary.

Photocopies of this release shall have the same authority as the original. This release will expire one year from the date of signatures on this form, unless revoked earlier by me in writing.

Date of signature

_____/_____/_____

Signature of student

Printed or typed name of student

Student's social security number (optional)

Date of birth

_____/_____/_____

CONSENT OF PARENT

I am the parent or legal guardian of the above student, and authorize the foregoing release of medical information to the student's school/school district and to appropriate health care providers.

Date of signature

_____/_____/_____

Signature of parent / legal guardian

Printed or typed name of parent / legal guardian