Medical Home - School Information Release

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.

When completed, this form should be handed or mailed to the school principal.

Release of Information

Patient/Student's First & Last Name:	Parent/Guardian's Name:	Phone number:
Patient/Student's School & District:	Principal's Name (if known):	School phone number:

I, the undersigned, authorize the release of information relating to the diagnosis/condition listed below regarding the above-named student to his/her LEA (school principal or designated Local Education Agency representative) 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's Signature:	Date:	If applicable, my consent expires:

Not included in this release are:

Physician Contact Info

Medical Home Provider (MD, DO, PA, NP) Name:	Phone Number:	Fax Number:
Mailing Address:	E-mail address:	
If not you, who is the best contact person:	Phone Number:	Fax Number:
Mailing Address:	E-mail address:	

Preferred Method and Time for Contact:

Diagnosis

Diagnosis/Condition:

Will this condition adversely affect the student's educational performance?

- ☐ YES Briefly describe impact:
- ☐ NO

Medical Home Provider Signature:	Date:

School Info

LEA's Name:	LEA's signature	Date
Best initial contact person:	Position:	
Mailing Address	Phone:	
Email address:	Fax:	

When complete, a copy of this form will be returned to the Medical Home Provider