Medical Record Release

This is to authorize ______________________________
(name of agency holding records)

____
(address of agency holding records)

To release medical records on:

____
(student's first, middle, and last name)

Responsible party: ______________________________
(parent/legal guardian)

To: ______________________________
(name of school)

____
(address of school)

Special Notations: ______________________________

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Signature of parent or guardian of minor