Print Form

Special Education Services
46 North Jackson Street
Sandusky, Michigan 48471
810-648-2200

PARENT/GUARDIAN RELEASE OF MEDICAL INFORMATION

STUDENT'S NAME: _____ **BIRTH DATE:** _____

STUDENT'S ADDRESS: _____ _____ Michigan _____
STREET **CITY** **STATE** **ZIP**

SCHOOL DISTRICT/SANILAC ISD _____

PLEASE CHECK BELOW, WHICH PHYSICIAN THE ISD CAN REQUEST INFORMATION

☐ **SANILAC ISD CONTRACTED PHYSICIAN**

☐ **PRIMARY PHYSICIAN'S NAME:** _____

PRIMARY PHYSICIAN'S ADDRESS: _____
STREET

_____
CITY **STATE** **ZIP**

The agencies and above listed physicians list above have my permission to share information. I authorize the use of telefax, photocopy, e-mail and/or verbally of this form for the release or disclosure of the information described on this form. I understand that all information is confidential and will be shared only with those that have a valid reason for sharing of information.

1) **All medical records or other information regarding the treatment and/or out patient care for the including psychological, medical, and physical.**

2) **Information about how the disability affects ability to complete tasks and activities of daily living in and around the school setting, including but not limited to classroom, gymnasium, and playground.**

3) **To provide the necessary prescriptions required for treatment and Medicaid billing proposes.**

4) **Sharing of student's current educational evaluations and diagnosis of eligibly for Medicaid billing proposes.**

_____ _____
PARENT/GUARDIAN SIGNATURE **DATE**