SPECTRUM ACADEMY
A Community of Learners

Student Health Care Plan

AUTHORIZATION TO RELEASE INFORMATION

(For medical purposes only)

Student's Name: _____

Date of Birth: _____

I hereby authorize Spectrum Academy to (check one):

- ☐ Obtain from the following
- ☐ Release to the following

Name of Health Care Provider: _____

Address: _____

Phone: _____

The following documents/information from the records pertaining to services received.

The documents to be released are described or listed as: _____

_____

These records are required for the specific purpose of: _____

_____

I understand that my authorization will remain effective from the date of my signature until a written and signed document is provided revoking previous authorization.

This information is to be used in the planning and sustaining an appropriate educational environment for the student. The confidentiality of the information received will be protected by the state and Federal guidelines regarding the collection, maintenance and dissemination of student records

(Family Education Rights and Privacy Act of 1974).

I have read and understand the nature of this release.

Name of Parent/Guardian/Designated Representative:

_____

Signature: _____ Date: _____