RAINBOW PEDIATRICS
AUTHORIZATION FOR RELEASE OF INFORMATION
BETWEEN HEALTH CARE PROVIDERS and EDUCATORS

Instructions: This form is to be used by the eligible parent/legal guardian (parents of a "dependent student" as defined by the "Internal Revenue Code") to request and authorize release of student health information. This release is specifically for release of medical information by and between the school identified below and Rainbow Pediatrics. Execution of this authorization is voluntary. This authorization specifically allows release of information to the specified individuals under the Family Education Rights and Privacy Act (FERPA) and the Health Information Privacy and Accountability Act (HIPAA).

Name of student/patient: ____

Date of Birth: ____________________________________

Student/Patient Address: ____

Rainbow Pediatrics Address: 44 Collins Drive, Suite 202, Middlebury, VT 05753

Healthcare Provider Name(s): ____

School name & address: ____

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I, ____ , the eligible parent/legal guardian of the above indicated student/patient hereby authorize the school and healthcare provider(s) identified above, and all persons working under their authority, to release any and all medical information from my educational record and health record with no limitations placed on medical history or illness, diagnostic and therapeutic information, referrals, lab and test results, prognosis, discharge summary, and reports of treatment provided.

This authorization is valid, unless otherwise modified in writing, for the duration of the above indicated student's/patient's tenure at the above indicated school.

I understand that this consent may be revoked or extended at any time, but only upon written notice, signed by me and delivered to the above identified school and healthcare provider(s).

A copy of this authorization shall be valid as the original.

____ __________________________________
Signature of Patient or Legal Guardian Date

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Witness