Livonia Public Schools

SECTION 504 – AUTHORIZATION FOR RELEASE AND EXCHANGE OF MEDICAL INFORMATION — FORM F

Student Name: _____ Date of Birth: _____

School Building Attending: _____ Grade: _____

Parent/Guardian Name: _____

Address: _____

Phone: _____ Email: _____

I hereby authorize the release and exchange of otherwise confidential medical information between the Livonia Public Schools and:

Physician's Name: _____

Address: _____

Phone: _____ Fax: _____

I understand that any information released or exchanged will be treated in a confidential manner by the District and will not be transmitted to a third party without my permission. This authorization is valid for a period of ninety (90) days unless earlier revoked by me in writing.

Date: _____

_____
Signature of Parent/Legal Guardian

_____
Relationship to Student

PLEASE FORWARD DOCUMENTS TO: