POLICY # G.1.K. EX1

Managing Health Care Requests- Medical Release

AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION

Student's Name: _____

Date of Birth: _____

Protecting the privacy of our students is important to Southeast College. The purpose of this form is to authorize Southeast College to collect and disclose your student's personal health information, such as your student's health care history, with doctors, nurses and other health care providers, as required, for the purpose of developing an Individual Health Care Plan and/or an Emergency Plan for your student.

As the parent/guardian, I may amend or revoke this consent at any time with written notice to Southeast College.

_____ _____

Parent/Guardian Signature Date

_____ _____

Student Signature Date

This authorization expires at the end of the current Southeast College academic school year, when Southeast College receives written notice that there has been a change in either custody or legal guardianship of your student, or when you revoke this consent, with written notice to Southeast College

Adoption Date: August 21/12	Revision Date: March 11/16