MoundsPark
ACADEMY

Authorization for the Release of Information for Upper School Students

The purpose of this authorization is to enable effective communication between appropriate school personnel and the named physician/clinic so as to better meet your child's health needs in relation to their school work.

Student Name: _____ Grade: _____ DOB: _____

Parent/Guardian Name: _____ Cell Phone: _____

Address: _____ Email: _____

I authorize Mounds Park Academy to release and/or obtain information from:

Physician: _____ Clinic Name: _____

Clinic Address: _____

Phone: _____ Fax: _____

The following information may be disclosed:

____ Medical History ____ Test Results ____ Education Assessments

____ Medications ____ Admission/Discharge Summaries ____ Psychological Testing

____ Clinic Visit Notes ____ Entire Medical Record ____ Other: _____

Statement of Authorization:

- I understand that this authorization takes effect the day that I sign it and expires one year from the date of my signature.
- I understand that I may revoke this authorization at any time by giving written notification.

Signature of Parent/Guardian: _____ Date: _____

Return form to:

____ Mark Segal, Upper School Director
____ Randy Comfort, Director of Guidance
____ Ashley Cooper, Counselor for Grades 7 - 12
____ Julie Koster, School Nurse
____ Patti Osman, Upper School Learning Specialist

Mounds Park Academy 2051 Larpenteur Avenue East St. Paul, MN 55109
Fax: (651) 777-8633 Phone: (651) 777-2555