AUTHORIZATION FOR RELEASE OF SCHOLASTIC INFORMATION

Student Information:

_____

(PRINT name) DOB SS#

_____

(Previous Names)

Information to be released from:

Name of Institution_____

Address_____

I request and authorize the above named institution to release all scholastic information of the current/former student named above to:

Medrecs, Inc
PO Box 4186
Seattle, WA 98194-0186 (206) 624-1420

Information to be Released:

All scholastic records to include but not limited to: records, report cards, transcripts pertaining to education and scholastic ability, all office, disciplinary and scholastic records, absence records, medical records, incident reports and teachers comments from the first date of enrollment to the present.

Purpose for which disclosure is being made: (Please check one of the following)

_____Attorney/Legal _____Insurance _____Personal

Student Authorization:

I understand that my express consent is required to release any scholastic information from the above referenced institution. I also understand that my express consent is required to release any health care information relating to testing/diagnosis, and/or treatment for HIV (AIDS Virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. You are specifically authorized to release all health care information relating to such diagnosis, testing, or treatment.

My Rights:

I understand that authorizing the use or disclosure of the information above is voluntary. I may revoke this authorization in writing at any time. To view the process for revoking this authorization, please read the Privacy Notice posted at the facility where your information is being released. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that once the information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

_____ _____

Signature of Student or Student's Authorized Representative Date Signed

This Authorization will expire 90 days from the date signed

A photocopy or facsimile shall be counted true and valid as original.