PARENT AUTHORIZATION FOR RELEASE OF SCHOOL AND EDUCATIONAL INFORMATION TO THIRD PARTY

Parent's Name: _____

Child's Name: _____

Child's Date of Birth: _____

Parent's Address: _____

Parent's Phone Number: _____

I hereby authorize ANY EDUCATIONAL FACILITY, INCLUDING PUBLIC SCHOOLS, PRIVATE SCHOOLS, DACARE FACILITIES, AFTER SCHOOL CARE FACILITIES, TUTORING FACILITIES, AND EXTRA-CIRRICULAR ACTIVITY FACILITIES, AND ANY OTHER MEDICAL PROFESSIONAL OF ANY TYPE to disclose any information about my child, _____ to include making and delivering a full copy of the child's entire file, to the Law Office of Susan Pniewski, Esquire, PA and any employees of said office, either by fax or by hand delivery.

I understand that this authorization is valid for one year from this date or until and may be revoked by me at any time except to the extent Law Office of Susan Pniewski, Esquire, PA has already taken action base on my authorization.

SPECIFIC UNDERSTANDINGS

I understand that this consent may include disclosure of Alcohol and Drug Abuse records and/or Psychiatric records and or HIV-related information (indicating that I have had an HIV-related test, or have HIV). I understand some information that may be disclosed may pertain to learning disabilities, federal and state programs, financial aid, and financial status.

By signing this authorization form, I am authorizing the use or disclosure of my protected health information as described above for the purposes of any legal proceedings. I understand this information may become part of a Court file and as such may become public record. This information may be redisclosed if the recipient as described on this form is not required by law to protect the privacy of the information, and such information is no longer protected by federal health information privacy regulations.

Parent's Signature: _____ Date: _____

Print Name: _____ Relationship to Student: _____

Tel. No.: _____ Address: _____