



**Disclosure/Release of Information
Between Patient's School and The Pediatric Care Center**

Patient's Name: _____ Date of Birth: _____

Patient's Address: _____

Patient's City/State/Zip: _____

Phone Number: _____

School Name: _____

School Address: _____

School City/State/Zip Code: _____

Phone Number: _____

Fax Number: _____

Teacher/Guidance/Social Worker Name: _____

Social Worker Ph. #: _____

I hereby authorize the above-named School/Teacher/Guidance/Social Worker to communicate with The Pediatric Care Center. Additionally I authorize the above-named School/Teacher/Guidance/Social Worker to release any paperwork requested or to discuss any Important Information about the above-named patient with The Pediatric Care Center.

Parent/Guardian Name: _____ Date: _____

Parent/Guardian Signature: _____

Reason for Release: