

Young Pediatrics

Release of Records and/or Medical Information Authorization to a **School**

This authorizes the providers and staff of Young Pediatrics to contact my child's teacher or school staff to discuss or exchange medical and psychological treatment and concerns of this child, both verbally and/or in print.

Child's name:

Date of Birth:

School:

Please send specific information regarding:

- Behavioral Concerns
- Grades
- Mental Health
- ALL INFORMATION (including the above)
- Other _____

This authorization may be revoked anytime by written request, or becomes void on patient's 18th birthday.

Signed: _____ Relation: _____ Date: _____

Please send written information to:

Young Pediatrics
4804 South State Route 159 OR FAX: 618-288-9308
Glen Carbon, IL 62034

For verbal communication or questions PH: 618-288-9305