The Learning Academy of St. Mark's

You Are Guided Today, To Lead Tomorrow.

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HIPAA Consent and Release Form

Student Name: ____________________________ Date of Birth: __________________

I hereby authorized ____ to
(Health Care Provider's Name and Telephone Number)

release my child's health information/history to The Learning Academy of St. Mark's. I give permission for you to consult with their faculty so that appropriate and safe care will be given to my child pertaining to their health care/needs and medications.

Parent Name: ____

Parent Signature: ______________________________________ Date: ________________