RISE Center
Where Special Kids Shine
THE UNIVERSITY OF ALABAMA

Medical Records Release Form

Child's Name: _____

Parent(s): _____

Primary Physician's Name: _____

Address: _____

Phone Number: _____ Fax Number: _____

Physician's Name: _____

Specialty: _____

Address: _____

Phone Number: _____ Fax Number: _____

Physician's Name: _____

Specialty: _____

Address: _____

Phone Number: _____ Fax Number: _____

I _____ approve the release of medical records and information from the above mentioned physician(s) to the RISE Center for the purpose of better serving my child and preserving the safety of my child while they attend RISE. I understand that my child's medical information will be requested from their physician only when necessary and I will be notified when these requests are made.

Parent/Guardian Signature: _____ Date: _____