

MADISON COUNTY BOARD OF EDUCATION
1275 F Jordan Road, Bldg. B
Huntsville, AL 35811
256-852-2557 Phone 256-852-1038 Fax

SECTION 504 MEDICAL INFORMATION RELEASE AUTHORIZATION

Student's Name: _____	Date of Birth: _____
Address: _____	Phone Number: _____
_____	School: _____

I, _____ for: _____	_____
Parent/Custodian	Student's Name
Hereby authorize: _____	
Printed Name of Doctor/Agency	
Address: _____	Phone Number: _____
_____	Fax Number: _____

to release to and receive from Madison County Schools Section 504 Coordinator the following (check all that apply):

- Most recent vision exam results and educational implications
- Most recent hearing exam results and educational implications
- Current Medications
- Current Diagnosis
- Doctor's orders
- Other: (please describe) _____
- Permission to speak directly with Doctor/Agency representative

The purpose and need for this disclosure is *to aid in the determination of eligibility for Section 504 of the Rehabilitation Act of 1973 and for continuity of care.*

This consent may be ended at any time by the individual, but ending the consent will not cancel any action that has already been taken as allowed by the form. Unless the individual wishes to cancel this consent at an earlier time, it will automatically stop upon the date and/or event/condition indicated: **one year from the signature date.**

It is understood that the duration of this consent will not be longer than would be necessary and reasonable for the purpose for which it is given.

Signature of Student (age 14 and older)	Date
Signature of Parent/Custodian	Date
Signature of Witness (other than Coordinator)	Date

Send Records to:

_____ **School**

Attn: _____, **Section 504 Coordinator**

 _____, **AL** _____