AUTHORIZATION TO RELEASE INFORMATION for CONCUSSIONS

Permission is hereby given to Dr. Alley of Marcellus Family Medicine for the Onondaga Central Schools, to obtain information from and/or release information to:

____

(Name and phone number/fax number of treating medical Dr.)

____

(Organization's address)

Regarding:

____

(Student Name) (Date of Birth)

For the purpose of determining readiness to return to athletic or physical education programing.

The Onondaga Central School District and Dr. Merritt are released from all legal responsibility which may arise from this act.

I, the undersigned, have read the above and authorize the medical staff of the facility to disclose such information as herein contained.

Signature: ____

Date: ____

This release is valid until.______________________________________

(Date)