

**AUTHORIZATION FOR RELEASE OF MEDICAL RECORD  
INFORMATION**

Student Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Mother's Maiden Name: \_\_\_\_\_

I hereby grant my permission to release information from my medical record to:

Ms. Gail Stryker, RN, BSN  
Fenway High School  
174 Ipswich Street  
Boston, MA 02215

Telephone: 617-635-9911 x 122  
Fax: 617-635-9204

Information requested (please check):

\_\_\_\_\_ Complete copy of medical record

\_\_\_\_\_ Copy of immunization record

\_\_\_\_\_ Student's most recent visit

\_\_\_\_\_ Psychological Evaluation

\_\_\_\_\_ Other: Please specify: \_\_\_\_\_

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date