BEACON COLLEGE

Authorization to Treat/ Release of Confidential Information

Name of Student: _____ DOB: _____

I hereby grant permission to the Beacon College Student Health Services staff to render any first aid/health care or emergency treatment to myself (son/daughter). I also grant permission for the above referenced Beacon College staff to arrange health care, emergency treatment or hospitalization at the accredited hospital or psychological facility when deemed medically necessary. I also authorize Beacon College Health Services to release confidential information regarding my care to the above mentioned health care providers.

- ❑ Check here if you also give permission to inform the following parents/guardians of any medical situations:

Parent Name: _____
Phone: _____

Parent Name: _____
Phone: _____

I understand that I may revoke this authorization in writing at any time.
Student Signature: _____
Parent Signature (if under age 18): _____
Today's Date: _____

rev. 3/9/17