Alena Ashenberg MD, Pediatrics
Boston Children's
Primary Care Alliance

ashenbergpedi.com
978-957-4300 | *fax* 978-957-3891

School Information Release

Patient name: _____

Date of birth: _____

Address: _____

City: _____ State:_____

Zip:_____

Phone: _____

Patient's school: _____

Authorization

❑ I authorize the release of school information to Dr. Alena Ashenberg.

❑ I give permission for Dr. Ashenberg and any employee of my child's school to discuss my child.

Signature

Parent/Guardian signature (if student is under 18):

_____

Date: _____

Patient signature (if 18 or older):

_____

Date: _____