



Physician Release Form for Epilepsy Scholarship

Scholarship applicants:

Please fill out this form in its entirety and send it to your physician along with a stamped return envelope addressed to you. You must include this sealed envelope from your physician in your application package, which is due no later than May 20th in the year you're applying.

Dear Dr. _____,

I am applying to the Epilepsy Alliance West Central New York | EPI scholarship.

As part of the application, I have been asked to supply a signature from a physician confirming that I have a medical diagnosis of epilepsy.

With this letter, I give you permission to release that information about me to Epilepsy Alliance West Central New York | EPI at 1650 South Ave, Rochester, NY 14620

Applicant Signature: _____

Address: _____

City: _____ State: _____ Zip: _____

Physicians:

Please sign below to confirm the medical diagnosis of epilepsy. **Please send this form back to the applicant in a separate signed and sealed envelope.** The applicant will include the sealed envelope in the application package.

Physician signature: _____ Date: _____