Kansas Produce Prescription Program for Frontier Kids
Necessary Data Sharing Agreement
Parent/Guardian Informed Consent Form

I hereby authorize USD [_____] to disclose my child [_____]'s free or reduced lunch program status and participation in any in-school nutrition education to AmberMed for the purpose of eligibility verification for the produce prescription program and data related to nutrition education received.

Parent/Legal Guardian Signature Date

Kansas Produce Prescription Program for Frontier Kids
Patient Information Release Authorization

Patient Name: _____ DOB:_____

I hereby authorize [_____] (Clinic Name) to release my child[_____]'s medical information to:

AmberMed Clinic
826 18th St Ste A
Hoxie, KS 67740

Specific Information to be released:

- ☒ Contact Information
- ☒ Health Metrics
- ☒ Provider Notes
- ☒ Diagnoses
- ☒ Dates of Service
- ☒ Insurance

Purpose of Release:
Ability to enroll and participate in the GUSNIP Produce Prescription Program run through AmberMed. This release will expire 18 months from the date of execution.

Signature of Parent/Legal Guardian: _____

Relationship to Patient: _____

Date: _____

Please Note: You have the right to revoke this authorization at any time by providing written notification to AmberMed. This authorization is only valid if signed and dated by the patient or their legal representative. The above listed medical clinics will only release the minimum amount of information necessary to fulfill the purpose stated above. If you have any questions regarding this authorization, please contact AmberMed at (785) 675-3018