MEDICAL RELEASE FORM
Botswana Government Training Sponsorships

I, _____, authorize any health care provider who treats me to release any and all information regarding my health to the Embassy of Botswana. This authorization covers all medical professionals, including, but not limited to, my primary care physician, any other medical specialist, and/or emergency room health professional I consult. Specifically, I allow the release all information, including diagnosis, prognosis, and treatment, regarding any illness or other medical condition I may have. The Embassy of Botswana is further authorized to release information about my medical condition to an other third party, which needs the information in order to participate effectively in the administration of my scholarship. This authorization is valid for the duration of my academic program.

Signed:_____ Date:_____

Dear _____