Release of Information Authorization

Student Name:____

Last First MI (Other)

Date of Birth:____/____/______ Phone #: ____-______-______

☐ I Authorize____

Name____

Address____

City__________________________State______________Zip________________

Information to be released:

☐ All Medical Records

☐ History and Physical Exam

☐ Psychological/Psychiatric testing

☐ Other (Specify):__________________________

☐ Immunization Records

Purpose of Disclosure:

1. I understand this authorization expires 6 months after signed.
2. I understand that I may revoke this authorization at any time by notifying organization in writing and that it will be effective on the date written notice is received (except to extent of action taken prior to receiving written notice).
3. I understand that information used or disclosed related to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal Privacy Regulations.
4. By authorizing this release of information, I understand that my health care and payment for health care will not be affected.
5. I understand that I may have a copy of the information described on this form and a copy of this form after I have signed it.

☐ Parent/Legal Guardian has received a copy of this form.

_______________________________________ _______________________________

Signature of Parent/Legal Guardian Date Witness Date

FOR OFFICE USE ONLY

Date request completed and sent ____

School District Person sending Request ___________________________________

Date records received ____