



Authorization for the Release of Medical Information

Student's Name: _____ Date of Birth: _____

To: _____
Physician's Name Physician's Address

Physician's Phone Physician's Fax

The under signed is hereby authorized to exchange, release, send, certify and make available the information, records, files or data herein described to the person(s) or institution(s) designated below:

Information to Provide Homebound Services _____ Medical Updates _____
Emergency Department Notes _____ Prior Assessments _____
Operative Report _____ Treatment Provided _____
Progress Notes _____ List of Medications _____

Person(s) Institution(s) to whom or to which information is to be released.

School School Nurse

I read and understand the above consent and authorize communication between my health care provider, medical staff and the school nurse. This may be by telephone, mail, person to person contact or fax. I consent and request that a photocopy of this authorization be accepted with the same authority as the original. I also give permission to share any medical information about my child's health with members of the educational team. This information will be given to those appropriate team members, in a confidential manner, on a need to know basis to meet the health and educational needs of my child.

I understand that this release is effective for the _____ school year, but that I may revoke my authorization at any time by providing written notice to the School City of Hammond. This authorization is subject to revocation at any time except to the extent the action has already been taken in reliance on this authorization.

Parent/Legal Guardian Signature Date

Witness Date