# Authorization for Release of Student Medical Information

## Patient Information

| Last Name | | First Name | | Middle |
|---|---|---|---|---|
| Address | | City | State | Zip |
| Birthdate | Parent Name | | Phone | |

## Information Requested

| Reason for Request<br>○ Continuity of Care ○ Legal Reasons<br>○ School Related ○ Special Ed<br>○ At request of individual ○ Other | ○ Immunization Records<br>○ General/Medical<br>○ Counseling Records<br>○ Emergency/Urgent Care<br>○ Diagnosis | ○ Neurological<br>○ Surgical<br>○ Orthopedic<br>○ ENT<br>○ Other____________________ |
|---|---|---|

## Release To

| Send medical information to the following via: ○ Fax ○ Mail | | |
|---|---|---|
| School Representative | | Title |
| Address | | |
| City | State | Zip |
| Phone | | Fax |

## Release From

| The following individual or organization is authorized to disclose health information for the student listed above: | | |
|---|---|---|
| Individual/Organization | | |
| Address | | |
| City | State | Zip |
| Phone | | Fax |

## Authorization

| I hereby authorize Collins-Maxwell CSD to release and/or receive medical information to/from the above party for the student listed. This authorization may include release of information concerning treatment of drug or alcohol use, drug related conditions, HIV/AIDS, and/or psychiatric conditions. | |
|---|---|
| I understand that this authorization shall remain in effect for the school year ______/______, unless an earlier expiration date is specified(________________). I also understand that I may withdraw this authorization at any time by written notification to the above parties involved. However, this written notification cannot affect actions that have taken place based on the prior authorization. | |
| Parent/Guardian Signature | Date |
| Signature of School Representative | Date |