Washington County School District Health Services

AUTHORIZATION FOR RELEASE AND USE OF HEALTH INFORMATION

This form will authorize the exchange of information between the student's health care provider and school professionals.

Student	DOB:	School:	Grade:

I authorize the release of the above-named student's health information

Medical Provider:
Phone: FAX:
City:

Medical Provider:
Phone: FAX:
City:

Medical Provider:
Phone: FAX:
City:

Medical Provider:
Phone: FAX:
City:

PARENT/GUARDIAN

1. This release shall remain in effect until expiration date below; I understand that I have the right to revoke this authorization to the school and student's physician on behalf of my minor child by providing written notice to the student's physician. Revocation does not affect releases of medical records made prior to the revocation.

2. I, the undersigned, authorize the release of information relating to the diagnosis/condition listed below regarding the above named student to his/her school and appropriate school personnel and authorize the school to release and discuss information and reports with the above named physician and /or his/her assigned office personnel.

3. I understand that the released records may become part of the student's educational records and may be forwarded to another school in which the student seeks or intends to enroll. The school and District will protect this information in compliance with the Family Educational Rights and Privacy Act(FERPA)

4. I understand that I have a right to receive a copy of this form after signing, and may inspect the information that is disclosed.

Specific information to be released:

☐ *Current History & Physical* ☐ *Immunization record* ☐ *Current Progress Note*
☐ *Medication Authorization* ☐ *Diagnosis/Current Health Condition(s)*
☐ *Other*_____

Parent/Guardian Signature: _____ **Date:** _____ **Expires: Graduation**

Fax/Mail records to:

Washington County School District

Nurse_____
Address: _____
Phone: _____ Fax:_____

3/15 revised