Release of Information Authorization

Student Name:____Date of Birth:__________________________

I Authorize: ____
Healthcare Provider/Clinic Name

to release information to:
Provo City School District
School Nurse:
Address/Fax:

Information to be released:
☐ All Medical Records ☐Immunization Records ☐ History and Physical Exam ☐ Psychological/Psychiatric testing
☐ Other:
Purpose of disclosure: Development of an Individualized Health Care Plan for School and/or 504 Plan

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 Relationship to Student Date

____
Witnessed by Title Date

FOR OFFICE USE ONLY
Date request completed and sent:
Date records received: