AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

YOUR INFORMATION			
LAST NAME:	FIRST NAME:	MIDDLE INITIAL:	DATE OF BIRTH:
ADDRESS	CITY/STATE:	ZIP CODE:	

Person/Organization Providing the Information	Person/Organization to Receive the Information
	Diana Tom, RN

Description of the Information to be Released
(Provide a detailed description of the specific information to be released)

Any pertinent medical information related to the Specialized Physical Healthcare Service(s) ordered by the physician as well as any information that will assist the school in providing a safe environment for the student. Medical information related to hearing and vision evaluation and/or treatment.

Description of Each Purpose for the Use or Release of the Information
(Provide a detailed description of the activity for which the information will be used.)

The information will be utilized to provide Specialized Physical Healthcare Services(s) to the student during school hours, as ordered by the physician and/or for planning for health related needs during school hours.

Will the health plan or provider receive money for the release of this information?

☐ Yes ☑ No

This authorization for release of the above information to the above named persons/organizations will expire on: *(date).*

I understand:

- I authorize the use or disclosure of my individually identifiable health information as described above for the purpose(s) listed. I understand that this authorization is voluntary.
- I have the right to revoke this authorization by sending my notice stopping this authorization to School Nurse at SCOE. The authorization will stop on the date my request is received. **Or** (*I understand the Notice of Privacy Practices provides instructions for me should I choose to revoke my authorization.)*
- I understand that I am signing this authorization voluntarily and treatment, payment or eligibility for benefits (*will or will not)* be affected if I do not sign this authorization.
- I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.
- I understand I have a right to receive a copy of this form.

Signature:	Date: