Authorization for the Release of Health Information

Patient Name:________________________________ Phone Number: ____________________

Address:____________________________________ City: ______________________________

State: _______________________ Zip code: ____________________

Date of Birth (DOB): _______________________________________

I hereby authorize __________________________ to release my medical information to:

____

Middletown Enlarged School District
223 Wisner Avenue
Middletown, NY 10940

Phone:
Fax:

ATTN:

Medical Records:
____

Authorization to Discuss Health Information:

By initialing here, _______ I hereby authorize ___________________________________ ; to discuss my health information with: *Middletown School District Health Office.*

TO BE READ AND SIGNED BY PATIENT/GUARDIAN:

I understand the following:

1. I may revoke this authorization at any time by providing written notice to the school.
2. I am signing this authorization freely, under no undue stress from any individual to do so.
3. I acknowledge that I have had the opportunity to review this authorization and understand its intent and purpose.

X____

Signature of Parent/Legal Guardian

____

Date