

Spring Branch Independent School District
HEALTH SERVICES
Authorization for Release of Medical Information

Student Name _____

Student Address _____

Date of Birth _____ SSN _____

Medical Record Number _____

I hereby authorize _____
(Name of Doctor or Medical Facility)

Physician Address _____

Physician Phone _____ **Physician Fax** _____

To disclose the following information from my (my child's) medical record (Check all that apply)

_____ Immunization _____ Lab Reports _____ Radiology and imaging reports

_____ Discharge summary _____ Clinical Documentation _____ Pathology reports

_____ Other (describe) _____

From my (my child's) medical records to

Name of school/school nurse _____

Address _____ City _____ State _____ Zip _____

Telephone _____ Fax _____

The purpose for which disclosure is authorized:

_____ Medical Care _____ Immunization _____ Other (specify) _____

I understand that:

1. I may inspect or receive a copy of the Protected Health Information
2. This authorization is voluntary and that I have the right to refuse to sign it.
3. I may revoke this authorization at any time.
4. This authorization will expire on _____ / _____ /20 _____ or 1 year after being signed.
5. The information disclosed is pursuant to this authorization **except** information protected by Federal and/or State regulations.
6. This authorization is also applicable to patients with drug or alcohol related diagnoses, protected by Title 42 of the Code of Federal Regulations.

Signature of Patient (parent/guardian if patient is a minor)

_____/_____/20_____
Date

Signature of Interpreter

_____/_____/20_____
Date