Green Island Union Free School District
171 Hudson Ave.
Green Island, NY 12183

Student Name: _____
Date of Birth: _____

Authorization to Exchange Information and Medical Records

I hereby authorize _____ to:

Please check one: ☐ Obtain From ☐ Release To

Person or agency: _____

Relationship: _____

Address: _____

_____

Phone: _____ Fax: _____

Expires upon discharge or specify:

Expiration date: _____

Or

Event /purpose of use:

_____

The specific information to be disclosed is:

- ☐ Medical history and Physical exam
- ☐ Psychiatric Records
- ☐ Psychological Reports
- ☐ Drug abuse treatment information
- ☐ Discharge Summary
- ☐ Treatment Plans
- ☐ Educational Records
- ☐ Return to school letter
- ☐ Other_____

Reason for authorization: (check all that apply)

- ☐ Coordination of Treatment/Provide ongoing treatment
- ☐ To coordinate treatment efforts with family
- ☐ Other _____

My Rights

I understand that I do not have to sign this authorization in order to receive treatment. However, I do have to sign an authorization form to receive health care when the purpose is to create health information for a third party.

I may revoke this authorization in writing at any time by sending notification.

_____ _____
Parent or Legal Guardian Date

_____ _____
Printed Name Relationship

_____ _____
Witness Date