

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:

- | | | |
|--|--|--------------------------------------|
| <input type="checkbox"/> Medical history and Physical exam | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Psychiatric Records | <input type="checkbox"/> Treatment Plans | |
| <input type="checkbox"/> Psychological Reports | <input type="checkbox"/> Educational Records | |
| <input type="checkbox"/> Drug abuse treatment information | <input type="checkbox"/> Return to school letter | |

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