PEORIA UNIFIED SCHOOL DISTRICT

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Acknowledgment of Disclosure of HIPAA protected information: The student, through their parent/guardian, is hereby requesting the below information for the benefit of the student's education. Disclosure is permitted by 45 C.F.R. §164.503(a).

COMPLETE IN FULL

Please print

STUDENT'S NAME	BIRTHDATE
SCHOOL STUDENT ATTENDS	GRADE

PARENT/GUARDIAN NAME	PARENT/GUARDIAN PHONE NUMBER

Release the following records:

- ☐ Care Plan/Treatment Plan related to diagnosis
- ☐ Doctor Order for _____
- ☐ Diagnosis: _____
- ☐ Immunization Records
- ☐ Other: _____

DOCTOR'S NAME	DOCTOR'S FAX
NAME OF DOCTOR'S PRACTICE	DOCTOR'S PHONE NUMBER

I give permission for the medical provider or healthcare facility listed above to release my student's medical information indicated above to the school nurse or to speak with the school nurse regarding the information requested in order to have necessary medical information needed in the school setting. I understand that this information will be used in a confidential and professional manner and in the best interest of the student, and that all information will be maintained in accordance with the Family Educational Rights and Privacy Act. I understand that my consent is voluntary and may be revoked in writing at any time. This release of medical information authorization expires at the end of the current school year.

_____ _____

Signature of Parent/Guardian **Date**

FOR OFFICE USE ONLY • DO NOT WRITE BELOW THIS LINE

Records should be sent to or discussed with the following school nurse:

SCHOOL NURSE NAME	PHONE NUMBER	
ADDRESS	CITY	ZIP
EMAIL ADDRESS	FAX NUMBER	