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:____

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)_______________________________________

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 12/5/2020 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.

____ ________/_______/20______

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

____ ________/_______20______

Signature of Interpreter Date

09/08
10/21 (ch)