HEALTH and WELLNESS SERVICES
1200 South Barr Street · Fort Wayne, IN 46802 · Phone: 260.467.1080 · Fax: 260.467.2862

Consent to Release Medical Information 2024-25

Student's Name: _____ Date of Birth: _____

School: _____

To: _____

(Physician's Name and Name of Practice) *(Physician's Address)*

I _____, authorize the undersigned is hereby authorized to exchange, release, send, certify, and make available the information, records, files, or data herein described to the person(s) or institution(s) designated below:

_____ Information to provide homebound services

_____ Behavior _____ Medical

_____ Prior assessments _____ Recommendations/limitations

_____ Medical updates _____ Progress notes

_____ Treatment provided _____ Other relevant information

❑ Person(s) Institution(s) to whom or to which information is to be released.

School Nurse/School: _____

School Nurse/School: Address: _____

❑ Mary Hess RN, BSN, Fort Wayne Community Schools Director, Health and Wellness Services

Address: Anthis, Health and Wellness Services, 1200 S Barr St, Fort Wayne, Indiana 46802

The purpose for this request to release medical information is:

☐ Medical Care/Treatment ☐ Other:

(Representative(s) Address of Institution(s) Required)

I read and understand the above consent and authorize communication between my health care provider, medical staff and the school nurse. This may be by telephone, mail, person-to-person contact or fax. I consent and request that a photocopy of this authorization be accepted with the same authority as the original.

I also give permission to share any medical information about my child's health with members of the educational team. This information will be given to those appropriate team members, in a confidential manner, on a "need to know" basis to meet the health and educational needs of my child. I understand that medical information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

I understand that this release is effective until_____, but that I may revoke my authorization at any time by providing written notice to Fort Wayne Community Schools. This authorization is subject to revocation at any time except to the extent the action has already been taken in reliance on this authorization.

If signed by other than parent of this minor child, please attach a copy of guardianship documents.

Relationship to Student_____

→Parent/Legal Guardian's Signature _____ Date: _____

FWCS School Nurse Signature _____