FORT WAYNE COMMUNITY SCHOOLS

# CONSENT TO RELEASE MEDICAL INFORMATION

Student Name:

School: DOB

To: Physician's Name

The under signed 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 ___ **Medical**

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

Mary Hess RN, BSN, Fort Wayne Community Schools Specialist, Health Services

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 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.

**Parent/Legal Guardian's Signature** _____ Date _____

FWCS School Nurse Signature _____ Date _____