

ONE WORLD COMMUNITY HEALTH CENTERS
SCHOOL-BASED HEALTH CENTER
AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Child Name: _____ **D.O.B.** _____
Personal Representative Name: _____
Address: _____ **Phone:** _____

As the personal representative of a child enrolled in a school-based health center operated by OneWorld Community Health Centers ("OneWorld"), I hereby authorize any physician, nurse practitioner, physician assistant, medical assistant or other health care staff of OneWorld to furnish records and to discuss details of my child's care and treatment at the school-based health center with certificated staff (school nurses, counselors, teachers, therapists, administrators) at Westside Community Schools (WCS).

I hereby authorize the School Based Health Center staff to furnish records regarding my child's care and treatment to my Primary Care Provider (PCP) _____. This authorization is to be ongoing until terminated by me or until my child is no longer enrolled in WCS. The purpose of the disclosure by OneWorld is to provide WCS certificated staff and my PCP with information about my child's health status, medications, treatments and clinic visits which is important for my child's safety and to promote the health and educational success of my child.

I understand and acknowledge that:

1. OneWorld may NOT condition my child's treatment, enrollment, or eligibility for benefits at the school-based health center on whether I sign this Authorization.
2. Medical information that is disclosed because of this Authorization may be subject to re-disclosure by the recipient and no longer protected by State or federal law.
3. This authorization remains effective while my child is enrolled in the Westside Community Schools. This authorization automatically expires when my child is no longer enrolled in the Westside Community Schools.
4. I understand that I may revoke this Authorization at any time by giving written notice to the medical professional or medical assistant on duty at the school-based health center where my child receives services.
5. I understand that my revocation is not effective as to disclosures already made and actions already taken based upon this Authorization.
6. I have received a copy of this document.

A photocopy or exact reproduction of this signed Authorization shall have the same force and effect as the original.

Signature of Patient or Patient's Personal Representative

Date

Relationship to Patient if Signed by Personal Representative