School City of Hammond
Department of Health Services

41 Williams Street, Hammond, IN 46320 – Phone (219) 933-2400 – Fax (219) 989-3957

Authorization for the Release of Medical Information

Student's Name: ____ Date of Birth: _________________

To: __________________________________ ____

Physician's Name Physician's Address

__________________________________ ____

Physician's Phone Physician's Fax

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 _______

Emergency Department Notes _______

Operative Report _______

Progress Notes _______

Medical Updates _______

Prior Assessments _______

Treatment Provided _______

List of Medications _______

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____

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

____

School School Nurse

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 for the ______________school year, but that I may revoke my authorization at any time by providing written notice to the School City of Hammond. This authorization is subject to revocation at any time except to the extent the action has already been taken in reliance on this authorization.

____ __________________________

Parent/Legal Guardian Signature Date

____ __________________________

Witness Date