MEDICAL RECORDS RELEASE AUTHORIZATION

I, ________________________________ hereby give permission to
Name of Student / Parent or Guardian re:

_________________________________________ to release from my files the following information:
(Name of Person making the Disclosure)

(Extent or Nature of Information to be Disclosed)

This information is to be release to ______________________________________________________
(Name of Person/Agency onto which the Disclosure is to be made)

The purpose or need for such disclosure is: ________________________________________________
_____________________________________________________________________________________

This information may be given __________________________________________________________
(Indicate Frequency)
_____________________________________________________________________________________

This consent is subject to revocation at any time except to the extent that action has been taken in
reliance therein and will otherwise expire on: _______________________________________________
(Date, Event, or Condition)

This information has been disclosed to you from records whose confidentiality is protected by federal law.
Federal regulations (HIPAA/FERPA) prohibits you from making any further disclosure of it without the
specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations.

Signature of Student – Parent/Guardian To Give Consent

Signature of Witness – RN/CSN

DATE

DATE