PARENT'S AUTHORIZATION TO RELEASE MEDICAL RECORDS

SCHOOL _____ RE: _____
Family Name First

HOME ADDRESS _____ ID NUMBER _____

DATE OF BIRTH _____ HOME PHONE NUMBER _____

PARENTS WORK OR CONTACT PHONE NUMBER _____

I, _____ Father / Mother / Guardian of _____ Student

Hereby authorize _____, _____
AGENCY/HOSPITAL/DOCTOR/CLINIC STREET ADDRESS

_____, _____ _____
City State Zip Code

To release my child's medical records to the Chicago Public Schools. This information is required for the following reason (specify purpose):

_____

_____

_____

_____

_____

_____

This authorization for disclosure is valid until _____, 20___ and, I understand that I may withdraw this authorization at any time. This authorization complies with the Health Insurance Portability and Accountability Act ("HIPAA") privacy provisions.

I understand that I have the right to inspect the information disclosed.

_____ _____
DATE SIGNATURE OF CONSENTING PARTY

_____ _____
WITNESS (PERSON IDENTIFYING CONSENTING PARTY) RELATIONSHIP