Heatly School
GREEN ISLAND UFSD

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Daniel Kalbfliesh *Superintendent*
Stephanie Bouchey *Principal*
Angela E. Legault *District Clerk*
Christopher Karwiel *Business Manager*
Kimberly Watkins *District Treasurer*

Student Name: _____
Date of Birth: _____

Authorization to Exchange Information and Medical Records

I hereby authorize _____to:

Please check one: ☐ Obtain From ☐ Release To
Person or agency: _____
Relationship: _____
Address: _____
_____
Phone: _____Fax: _____

Expires upon discharge or specify:

Expiration date: _____

Or

Event /purpose of use:

_____

The specific information to be disclosed is:

☐ Medical history and Physical exam ☐ Discharge Summary ☐ Other_____ ☐ Psychiatric Records ☐ Treatment Plans

☐ Psychological Reports ☐ Educational Records

☐ Drug abuse treatment information ☐ Return to school letter

Reason for authorization: (check all that apply)

☐ Coordination of Treatment/Provide ongoing treatment

☐ To coordinate treatment efforts with family

☐ Other _____

My Rights

I understand that I do not have to sign this authorization in order to receive treatment. However, I do have to sign an authorization form to receive health care when the purpose is to create health information for a third party.

I may revoke this authorization in writing at any time by sending notification.

_____Parent or Legal Guardian Date

_____Printed Name Relationship

_____Witness Date