West Carrollton School District
Release of Medical Information

Student Name: _____ DOB: _____

Address: _____

Please select the records that need to be released or disclosed:

_____ Inpatient Records
_____ Office Visit Records
_____ Test Results
_____ Emergency Dept. Records
_____ Discharge Summary
_____ Immunizations
_____ Psychological/Psychiatric
_____ Outpatient Clinic Records
_____ Other_____

The following individual or organization is authorized to disclose the above information:

Name: _____

Address: _____ City: _____ State: _____

Phone: _____ Fax: _____

I hereby grant permission for _____ with the West Carrollton School District to ____Exchange ____Receive ____Release medical/behavioral/academic information with/from/to the treating practitioner or facility stated above for the purpose of providing health care or for addressing health needs during school hours.

I understand that this authorization shall remain in effect for the entire _____ school year. I also understand I may withdraw this authorization at any time by written notification to the parties involved.

Date: _____

Name of Parent or Guardian: _____

Signature of Parent or Guardian: _____