AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Student Name _____ Date of Birth_____

Street Address _____

City; State; Zip _____ Phone #: _____

Doctor's Name and Number _____

Authorization for Release of Records

I hereby authorize my child's Doctor to release to the Gates Chili School District information related to the immunization and health records for the purposes of enrollment. Such information will include a copy of my child's health record, immunization history, and other medical information necessary for the enrollment process. I understand that any information released by my child's doctor to the Gates Chili School District will be used for the sole purpose of determining whether my child is eligible to be enrolled in public school as required by New York State law. I further understand that no child may be admitted to school or allowed to attend school for more than 14 days without an appropriate immunization certificate or acceptable evidence of immunization. In the event that proof of immunization is not provided within the legal time frame, I understand that my child's admission to school will be denied and the local health authority will be notified.

_____ _____

Signature of Parent/Guardian Date

Authorization for Other Purposes

I further authorize my child's Doctor to release the following information for the purpose described:
Physicals to comply with NYS health regulations and sports requirements.
Immunizations to comply with NYS health regulations.
Authorizations for prescriptions to be administered by the nurse during school hours.
Sports related clearances to allow for reinstatement in athletic programs after an injury.
Hearing Exam results for maintenance of the health history.
Eye Exam results for maintenance of the health history.
Scoliosis Exam results for maintenance of the health history.
Other (specify)_____

_____ _____

Signature of Parent/Guardian Date

This authorization expires on my child's last date of enrollment in the Gates Chili School District. I understand that I may revoke this authorization in writing, by submitting that revocation to the school health office. A copy of this authorization has been provided to me and will be presented to my child's Doctor when the information authorized to be released is requested.

This form complies with HIPAA regulations.