

**Santa Fe Trail School District  
USD #434  
Authorization to Disclose/Obtain Medical Information**

**This authorization permits USD #434 to disclose/obtain your health information, including information about medical treatment, substance abuse treatment, mental health treatment and HIV/AIDS status. Please review it carefully.**

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
School: \_\_\_\_\_ SSN: \_\_\_\_\_  
Parent/Guardian Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_

I hereby authorize Doctor/Facility listed below:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_

To release information to and/or receive information from:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_

For the following designated purpose(s):

- \_\_\_ 1. To facilitate evaluation of your child's individual education program.
- \_\_\_ 2. To determine health needs of your child which may required special services during school
- \_\_\_ 3. To facilitate school health services which you may wish for your child
- \_\_\_ 4. To provide school district personnel with a better understanding of your child's health needs
- \_\_\_ 5. Other \_\_\_\_\_

The records to be disclosed are:

- \_\_\_ General Health History
- \_\_\_ Physical Examination/Treatment/Discharge Report
- \_\_\_ Immunization Records
- \_\_\_ Records related to HIV/AIDS
- \_\_\_ Other \_\_\_\_\_

- This authorization may be revoked in writing at any time and will automatically expire on June 30<sup>th</sup> at the end of the school fiscal year.
- A photocopy of this authorization will constitute a valid authorization
- If deemed necessary by USD #434, I authorize this information to be sent via facsimile (fax) transmission
- The physician, facility, and their employees are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

\_\_\_\_\_  
Signature of Parent or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Student

Notice to Recipient: The recipient of the enclosed information is not authorized to use this student's medical records for any purpose other than for that stated above or to disclose any information from the record to any other person of facility without specific written authorization from the parent or legal representative of the student to do so.