CONSENT FOR RELEASE OF INFORMATION

HORSEHEADS CENTRAL SCHOOL DISTRICT
143 HIBBARD RD
HORSEHEADS, NY 14845

Student Name:	Date of Birth:	Gender: M F NB

This form permits the mutual exchange of information between the following parties:

Horseheads Central School District 143 Hibbard Rd. Horseheads, NY 14845	Medical Provider Name: ________________________ Medical Office Name: __________________________ Address: ____________________________________ Phone Number: _______________________________

Extent or Nature of Information to be Released:

__ X___ Medical records and evaluations __X___ Immunization records ______ Other (specify):_________________________	

Purpose or Need for Information:

The information will be used in relation to services provided in the educational environment.

Acknowledgement of Terms of Release of Information:

1. I understand that I may revoke this authorization at any time by notifying, in writing, either of the parties listed above; however, that revocation won't have any effect on any actions taken before the receipt of the revocation.
2. I acknowledge, and hereby consent, that the released information may contain alcohol, drug abuse, HIV testing, HIV results, or AIDS information. If I do not consent to the release of such information, I must initial here. _____ (Initials)
3. I understand that if the organization or individual authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal medical privacy regulations.
4. I understand that the person or organization providing the information may not condition my treatment, payment for that treatment, enrollment or eligibility for benefits on my signing this authorization.
5. I understand that I may refuse to sign this authorization and that it is strictly voluntary.

I hereby authorize the release of the information indicated above. I understand that the information to be released is confidential and protected from disclosure. If the signer is not the student, I further certify that I am the parent or legally appointed guardian of the student and have the authority to sign this release for the above-referenced student.

This consent to release information will be in effect until the student is no longer enrolled in the Horseheads Central School District or otherwise revoked, whichever is sooner.

Signature of student/person acting for student:	Relationship	Date Signed		

Revised
7/13/23