Patient Name: ________________________________ ______Male ______Female

Medical Record # ______________________

Address: ____
Street City State Zip Code

Phone: (________)________________________ Date of Birth: ____________________ Age: _________ Grade: ________

*_____ I authorize my child to receive services from the Pediatric School Program.
Initials

*_____ I authorize use or disclosure of the above named individual's health and educational information as described to be released to the school or agency listed below. Children's Hospital of Illinois at OSF Saint Francis Medical Center Pediatric School Program has permission:
Initials

____ to release to _____ to obtain from _____ to verbal exchange with

*_____ I decline the services of the Pediatric School Program.
Initials

School or Agency: ______________________________ District: ______________________________

Phone: ____________________ Fax: _______________________ Teacher/Counselor: ____________________________

Address: ____ County: ___________________________

The following information may be included:

_____ Attendance _____ Educational needs/IEP _____ Admission & Discharge dates

_____ Class assignments _____ Medical diagnosis _____ Tutoring request

I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to the information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition _________________. If I fail to specify an expiration date, event, or condition, this authorization will expire one year from the date of the signature on this form.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization, which will prevent disclosure of information. I understand that the above named persons or organization authorized to make the requested disclosure may not condition treatment or payment on completion of this form. I understand I have the right to inspect or copy the information to be used or disclosed. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and information may not be protected by federal privacy laws. If I have questions about disclosure of health information, I can contact OSF SFMC privacy officer at 309-655-2734.

This release was: _____ signed in person _____ received via telephone with 2 witnesses listed below _____ returned via mail

____ ___________________________
Signature of patient or legal representative Date

____
If signed by legal representative, relationship to patient/authority to act for individual

____
Signature of witness(es) who can verify patient identity

For High School or Junior High Students (if possible):

Home Room Teacher/Counselor: ____

Class ________________________________ Teacher ______________________________________

Class ________________________________ Teacher ______________________________________

Class ________________________________ Teacher ______________________________________

Class ________________________________ Teacher ______________________________________

Class ________________________________ Teacher ______________________________________

Class ________________________________ Teacher ______________________________________

Class ________________________________ Teacher ______________________________________

Class ________________________________ Teacher ______________________________________

Class ________________________________ Teacher ______________________________________