



# York Catholic High School

601 E. Springettsbury Avenue, York, PA 17403  
717.846.8871 ♣ www.yorkcatholic.org

## **STUDENT MEDICAL RELEASE FORM** *Please Print*

Student Last Name \_\_\_\_\_ First \_\_\_\_\_ Middle Initial \_\_\_\_\_

Date of Birth \_\_\_\_\_ Phone \_\_\_\_\_

As the parent/guardian of the above stated student, I authorize York Catholic's guidance counselors, nurse, and/or administration (principal, assistant principal, or dean of students) to receive health information and medical updates from:

Doctor's/Therapist's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

CHOOSE:  Both Fax & Verbal Release  Fax release only  Verbal release only

I authorize the disclosure/release of the following information related to the following purpose(s):

Academics  Continued care in school setting  Other (specify): \_\_\_\_\_

- I understand the information in my health record may include information relating to health and wellness as well as current and past medical health. It may include information about behavioral or mental health services and treatment for alcohol and drug abuse.
- I understand this authorization is valid for one school year, currently 20\_\_ to 20\_\_, unless revoked by my written notice, provided said notice is received prior to release of the above designated information.
- I understand authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to receive treatment/assistance.
- I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about the disclosure of my health information, I may contact the Principal at 717-846-8871 x212.

Parent/Guardian Name: \_\_\_\_\_

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_