YORK CATHOLIC
MIDDLE & HIGH SCHOOL
601 E Springettsbury Ave
York PA 17403
717-846-8871
yorkcatholic.org

STUDENT MEDICAL RELEASE FORM

Please Print

_____

Student Last Name First Name Middle Initial

Date of Birth_____ Phone _____

As the parent/guardian of the above stated student, I authorize York Catholic's school 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 do not need to 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 x1312.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Date: _____