The Episcopal Day School of Evergreen

P.O. Box 1630, Evergreen CO 80437
303-674-9253 (voice) 303-674-1793 (fax)

AUTHORIZATION FOR THE EXCHANGE OF HEALTH INFORMATION

Child's Name: _____ Date of Birth: _____

I hereby authorize _____ [*insert health care provider name & title*.]

and _____ [*insert name & title of school official*]

to exchange health information/records for the purpose listed in the box below.

_____

_____

Address & phone number of health care provider

Description:

The health information to be disclosed consists of:

Purpose: This information will be used for the following purpose(s):

1. **Health assessment and planning for health care services and treatment in school.**
2. **Medical evaluation and treatment**
3. **Immunization record**
4. **Other: _____**

_____

Authorization

This authorization is valid for one calendar year. It will expire on _____ [insert date]. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent.

_____

Parent/Guardian Signature Date

Copies: Parent(s)/Guardian
Physician or health care provider releasing the health information.
School official requesting/receiving the health information.