Long Beach Catholic Regional School
735 West Broadway • Long Beach, New York 11561
Phone 516 432-8900 • Fax 516 432-3841

Date:_____

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I, _____, parent/guardian, authorize the release of all pertinent medical records and information regarding:

Student Name:_____ Date of Birth:_____

The healthcare providers listed below may disclose the following protected health information: (check all that apply)

- Immunizations
- Health Appraisals
- Past/Current medical condition information and its impact on attendance, school programming and special needs
- Other _____

Healthcare providers authorized to release information:

Name_____ Address_____

Phone#_____ Fax#_____ _____

Name_____ Address_____

Phone#_____ Fax#_____ _____

Name_____ Address_____

Phone#_____ Fax#_____ _____

Date Signature of Parent/Guardian Relationship