Cretin-Derham Hall

Co-Sponsored by the Sisters of St. Joseph of Carondelet and the Brothers of the Christian Schools

Authorization for Release of Information

Student Name: ______________________________ Date of Birth: ____________________ Grade: _____

Parent/Guardian Name: ______________________________ Relationship to Student: ___________________

Phone Number: _________________________ Email Address: _____________________________________

Home Address: ____

I authorize Cretin-Derham Hall to release, and/or obtain information from:

Physician: _______________________________ Clinic Name: _____________________________________

Phone Number: _________________________ Fax Number: _________________________

Clinic Address: ____

The following information may be disclosed:

Medications	Immunizations	Test Results
Medical History	Surgical History	Admission/Discharge Summaries
Clinic Visit Notes	Entire Medical Record	
Other: ______________		

This authorization allows for effective communication between appropriate school personnel, and the named physician/clinic. I hereby authorize the disclosure of the information described above, and understand that my authorization may be revoked at anytime with written notification. It is otherwise expired one year after the signature date.

Signature of Parent/Guardian: ______________________________ Date: _________________________

Please return to:
CDH School Nurse
550 Albert Street South St. Paul, MN 55116
Fax: 651.696.3394
Phone: 651.696.3346