GOUVERNEUR CENTRAL SCHOOL DISTRICT
Delivering the Promise of a Brighter Future

Bev Martin, RN
Head Nurse

HEALTH OFFICE
133 East Barney Street
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Melissa Breckenridge, RN
Elementary School

Christine Sitts, RN
Elementary School

Marla Shampine, RN
Middle School

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High School

AUTHORIZATION FOR RELEASE OF RECORDS

Child's Name_____   DOB:_____

This authorization is written permission for my child's Health Care Provider to disclose their protected health information as directed below:

I, _____, hereby authorize Community Health Center and/or_____
　　　　　　(Parent/guardians name)　　　　　　　　　　　　　　　　　　　　　　　　　　　　*(Doctor's Name)*

to disclose my child's protected health information to:

> *Gouverneur Central School District*
> *Health Office*
> *133 East Barney Street*
> *Gouverneur, NY 13642*

The specific information to be disclosed includes:

> *HEALTH and SHOT RECORD and/or PHYSICAL EXAM*

The protected health information will be disclosed for the following purposes:

> *School Requirements and/or other Requirements for student to participate in school related activities and programs.*

I understand that this consent is for the duration of my child's enrollment at GCSD.

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notice to my child's doctor.

I understand that the revocation is only effective after it is received and recorded by my child's doctor and is not effective to the extent that my child's doctor has already relied upon the authorization.

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to inspect or copy the protected health information to be disclosed as permitted by federal law (or state law to the extent the state law provides greater access rights)

_____   _____
Signature of Parent or Legal Guardian   Date