Covenant Clinic
Wheaton Franciscan Healthcare

Consent to Release Private Data

Parent(s) or Guardian, this form allows information about your child to be exchanged between your child's school and medical provider. Please complete and sign the authorization at the bottom of this form.

Date:_____

Patient's Full Name: _____ Date of Birth: _____

School:_____ Grade: _____

Parent's or Guardian's Name: _____

Parent's or Guardian's Address: _____

I authorize _____
(School Name)

_____
(Address)

_____
(City) *(State)* *(Zip Code)*

Check either or both boxes, as needed.

❒ To release information to:

❒ To obtain information from:

Wheaton Franciscan Healthcare
(Name, Title)

2710 St. Francis Drive, Suite 210
(Address)

Waterloo **Iowa** **50702**
(City) *(State)* *(Zip Code)*

The information to be released:

❒ Office School Records (name, address, birthdate, sex, attendance record, grade level, grades, class rank, standardized group test results)
❒ Health Record
❒ Psychological Reports
❒ Special Education Records *(including related services)*
❒ Teacher, Counselor, Staff Observations
❒ Chemical Abuse/Dependency Report
❒ Medical Report *(including related services)*
❒ Psychiatric Report
❒ Social Work Report

❒ Other *(specify)* _____

❒ Other *(specify)* _____

The purpose for the request: **Medical Evaluation**

I understand that this authorization takes effect the day that I sign it. It expires on _____ or no more than one year from the date of my signature. I also understand that I may chage this authorization at any time.

Parent's or Guardian's Signature: _____ Date:_____

146119 5/2/14 tm

White - Clinic Yellow - School