Passaic County Technical Institute
School Health Services
45 Reinhardt Road
Wayne, NJ 07470
Telephone: 973.389.4225/2035/4145/4226
Fax: 973.389.4125/973.790.6670

MEDICAL RECORDS RELEASE AUTHORIZATON

I, _____, hereby give
Name of Student / Parent re:

permission to _____
(Name of Person making the Disclosure)

to release from my files the following information: _____

_____
(Extent or Nature of information to be Disclosed)

This information is to be release to _____

_____
(Name of Person/Agency on to which the Disclosure is to be made)

The purpose or need for such disclosure is: _____

_____

This information may be given _____
(Indicate Frequency)

_____

This consent is subject to revocation at any time except to the extent that action has been taken in reliance thereon and will otherwise expire on:

_____
(Date, Event, or Condition)

This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulation (HIPAA/FERPA) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations.

_____

SIGNATURE OF STUDENT / PARENT / GUARDIAN TO GIVE CONSENT DATE

_____

SIGNATURE OF WITNESS / RN/CSN DATE