Webb City R-7 Schools

PATIENT AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

2018-2019

Patient Name: ________________________________Date of Birth: _____________
Address: ____

By signing this I authorize the said doctor below to use and/or disclose the specified protected health information listed about me to or for the parties listed below.

I authorize the following physicians: _______________________________________
to release the specified information listed below to Webb City R-7 Schools.

- ❏ Immunizations Records
- ❏ Health Records
- ❏ Other____

I hereby acknowledge my authorization to release the above referenced patient health information as directed by my instructions.

________________________________ ________________________________
Signature of Parent/Legal Guardian Relationship to Patient

________________________________ ____________________________
Printed Name of Parent/Legal Guardian Date

____
Witness Signature