

**PARENT RETURN THIS FORM TO SCHOOL**

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**AUTHORIZATION FORM FOR RELEASE OF PROTECTED HEALTH INFORMATION**

**PARENT PLEASE FILL FORM OUT COMPLETELY**

I, \_\_\_\_\_ hereby authorize LaSalle County Health Department to  
(Parent's Name or Personal Representative)  
release my child's immunization record to my child's current school district from the designated record set  
of \_\_\_\_\_ whose birthdate is \_\_\_\_\_.  
(Child's Name)

I understand that I have the right to revoke this authorization by giving written notice to the health department. I understand that is the health department has already used or released my health information in reliance of this authorization, that I cannot revoke the authorization. If I refuse to sign this authorization, the above-described health information will not be disclosed except as provide by law.

I understand that the health department may not condition treatment, payment, enrollment or eligibility for benefits on my signing this authorization unless I ask to receive health care solely for the purpose of creating protected health information to be disclosed to a third party or as otherwise authorized by law.

I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that this authorization is valid until the date of expiration listed below, or until I revoke it in writing by delivering a written revocation to the health department.

I have a right to inspect and copy the information contained in my designated record set. I am entitled to a copy of this authorization if the health department is seeking this authorization.

This authorization for release of protected health information terminates one year from today on \_\_\_\_\_.  
(Date 1 year from today)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Parent's Signature or Personal Representative)

If you are the personal representative of the patient, please specify your relationship to the patient:

→ \_\_\_\_\_  
(Relationship to the patient)