WEST OSO INDEPENDENT SCHOOL DISTRICT

OFFICE OF THE SUPERINTENDENT
5050 ROCKFORD DRIVE
CORPUS CHRISTI, TEXAS 78416

PHONE: (361) 806-5900 FAX: (361) 225-8308

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Parent Name: _____ Social Security #: _____

I request and authorize _____ to release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

Definition: Student Immunization Records

☐ Yes ☐ No I authorize the release of my (Child) Immunization Records.

☐ Yes ☐ No I authorize the release of any records regarding Immunization Records to the person(s) listed above.

Parent Signature: _____ Date Signed: _____

Patient is a Minor Parent signature required for authorization

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.

"Nurturing a Culture of Success: Whatever it Takes!"