Cretin-Derham Hall

Co-Sponsored by the Sisters of St. Joseph of Carondelet and the Brothers of the Christian Schools

Authorization for Release of Information

Student Name: _____ Date of Birth: _____ Grade: _____

Parent/Guardian Name: _____ Relationship to Student: _____

Phone Number: _____ Email Address: _____

Home Address: _____

I authorize Cretin-Derham Hall to release, and/or obtain information from:

Physician: _____ Clinic Name: _____

Phone Number: _____ Fax Number: _____

Clinic Address: _____

The following information may be disclosed:

- ❑ Medications
- ❑ Medical History
- ❑ Clinic Visit Notes
- ❑ Evaluations
- ❑ Other: _____
- ❑ Test Results
- ❑ Admission/Discharge Summaries

This authorization allows for effective communication between appropriate school personnel, and the named physician/clinic. I hereby authorize the disclosure of the information described above, and understand that my authorization may be revoked at anytime with written notification. It is otherwise expired one year after the signature date.

Signature of Parent/Guardian: _____ Date: _____

Please return to:
CDH School Counselor
550 Albert Street South St. Paul, MN 55116
Fax: 651.696.3366
Phone: 651.696.3312