

Cardinal Hickey Academy
1601 West Mount Harmony Road
Owings, Maryland 20736
(301) 812-0404

**Release of Health Information Authorization Form
2009-2010 School Year**

Student Name _____

I hereby authorize Cardinal Hickey Academy's health officials to share health information and health history with the other staff members on a need to know basis. This includes the Homeroom and Special teachers that have the student in their class. The purpose of this disclosure is for the teachers to be prepared in advance for any medical emergencies.

I also authorize release of medical information to Emergency Medical Personnel in the case of a medical emergency.

The health information to be disclosed will be from the health record that is maintained in the health room by the medical staff. This includes information from the Health Inventory, Emergency Record Information, Immunization records and Medication Authorization.

This authorization is valid for one school year (August 2008 thru June 2009). I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I also understand that this information is released to help with the treatment of my child while attending Cardinal Hickey Academy.

Student Name

Date of Birth

Teacher / Grade

Parent or Guardian Signature

Date