Legacy Prep Charter School
Health Services
1500 Daniel Payne Drive
Birmingham, AL 35214

REQUEST FOR CONFIDENTIAL HEALTH/MEDICAL RECORDS

Please send health/ medical records and information regarding:

Student: _____ DOB: _____

Address: _____

Phone: _____

Please send:

_____ Health Information and Medical Records only
_____ Other: _____

From Health Care Provider (list name/ facility) _____

_____

_____

by e- mail to: _____.

In signing this request, I certify that the email pphillips@legacyprepal.org is in a secure and confidential location unable to be accessed by anyone other than Nurse Pamela Phillips R.N./Head Nurse.

_____

Legacy Prep Charter School Nurse | Office Phone | Date School

NOTE: HIPPA – compliant authorization/release signed by the above named student's parent/guardian/ legal representative should accompany this request

Legacy Prep Charter School
Health Services
1500 Daniel Payne Drive
Birmingham, AL 35214
Head Nurse: (205)573-0777 ext. 1115

AUTHORIZATION TO OBTAIN AND EXCHANGE CONFIDENTIAL HEALTH/MEDICAL RECORDS AND INFORMATION

The undersigned parent/guardian/legal representative of: _____,
(DOB: _____) a student at Legacy Prep Charter School, hereby authorize the exchange of health/medical records and information to occur between **Legacy Prep Health Services** nursing staff and:

_____

Address: _____ Phone: _____.

USE AND DISCLOSURE shall be for the planning and implementation of any health related care to be provided during school hours and school-related activities.

I specifically authorize the release/exchange of the following records pertaining to my child, if such information/records exist:

_____ Health information and medical records only

_____ Other: _____

I further authorize the Legacy Prep Health Services nursing staff to share such records and/or information pertinent to my child's school progress with school personnel. In signing this authorization, I am certifying to the Legacy Prep Health Services nursing staff and the above-named provider that I have the lawful right to make this request and that I consent to the release of the above information. I understand and agree that unless earlier revoked, this authorization will expire in 180 days from the date shown below.

_____ _____

Date Signature of Parent, Guardian, or Legal Representative