



### Franklin School Based Health Center Release of Information

I \_\_\_\_\_, the parent or legal guardian of \_\_\_\_\_

(Parent/legal guardians name)

(Student's Name)

whose date of birth is \_\_\_\_\_, give my permission for \_\_\_\_\_

(Doctor's Name)

to share the all of the student's health records with Jordan Health at Franklin School Based Health Center. Please include the most recent physical examination and immunization records, and the following information if initialed:

\_\_\_\_\_ Mental Health  
(Initials)

\_\_\_\_\_ HIV/AIDS  
(Initials)

\_\_\_\_\_ Alcohol/Drug treatment  
(Initials)

I am requesting these health records so Jordan Health can provide school based health care services to the student listed above.

My permission to share is valid for as long as the student is enrolled in the Jordan Health at Franklin School Based Health Clinic.

I understand that:

- I may cancel my permission at any time. I can do so by writing to: Practice Manager, Jordan Health at Franklin, 82 Holland Street, Rochester, NY 14605. If the health record has already been shared it may be too late to cancel my permission.
- Jordan Health at Franklin may share the health record as allowed by State and Federal law.
- If I have given permission to share mental health, HIV/AIDS, or alcohol/drug treatment records, Jordan Health at Franklin may not share that information without my permission unless permitted by State or Federal law.
- Giving my permission to share the student's health records is voluntary and that his or her treatment, payment or benefit eligibility is not conditional upon my permission. However, I understand that the student may be denied treatment in some cases if I do not sign this form.

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Describe how this person has legal authority to sign this form: \_\_\_\_\_

I have given the parent/guardian a copy of this signed form: \_\_\_\_\_

Staff Member Signature and Date

**To the practice receiving this authorization to release information: Please fax or mail to:**

Jordan Health at Franklin  
322 Lake Avenue  
Rochester, NY 14608  
Fax: 585-336-5525

Questions – please call Nicole Schembra, RN, BSN, Practice Manager at 585-324-3726