KING WILLIAM COUNTY PUBLIC SCHOOLS
AUTHORIZATION OF PHYSICIAN TO RELEASE INFORMATION

I, ____, hereby authorize
(full name of employee/patient)

____to release to
(individual or organization holding the medical records)

____
(individual or organization authorized to receive the medical information), the following medical information from my personal medical records:

____

____
(Describe generally the information desired to be released).

I give my permission for this medical information to be used for the following purpose:

____

____
but I do **not** give permission for any other use or re-disclosure of this information.

(Note: Several extra lines are provided below so that you can place additional restrictions on this authorization letter if you want to. You may, however, leave these lines blank. On the other hand, you may want to (1) specify a particular expiration date for this letter (if less than one year); (2) describe medical information to be created in the future that you intend to be covered by this authorization letter; or (3) describe portions of the medical information in your records which you do not intend to be released as a result of this letter.)

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____

____

Full name of Employee or Legal Representative

____

Signature of Employee or Legal Representative

____

Date of Signature(s)____

July 2016