Honolulu Waldorf School

MEDICAL RECORD RELEASE FORM

Patient (Student) Full Name: _____

Date of Birth: _____
Month / Day / Year

I hereby authorize the below listed entity to release medical information to the Honolulu Waldorf School:

Physician Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Tel: _____ Fax: _____ Email: _____

Medical Information Requested:

- ❑ Immunization Record
- ❑ Most Recent Physical Examination
- ❑ TB (PPD) Clearance
- ❑ All Records

_____ _____
Full Name: Parent or Legal Guardian, Signature: Parent or Legal Guardian,

_____ _____
Patient (18 years of age) Patient (18 years of age)

_____
Date

This release authorizes the disclosure of records for one year from the date signed above. I understand that these records are protected under Federal and/or State law and cannot be disclosed without written consent unless otherwise provided by law. I further understand that the specific type information to be disclosed may, if applicable, include: diagnosis, prognosis, and treatment for physical and/or mental illness, including treatment of alcohol or substance abuse, auto-immune deficiency syndrome (AIDS), AIDS related complex (ARC) or human immunodeficiency virus (HIV) infection for any admissions. I understand that I have the right to revoke this consent at any time unless the facility, which is to make the disclosure of information, has already done so in reliance on the consent.

Please send all records directly to:

Honolulu Waldorf School Registrar Office
350 Ulua Street
Honolulu, Hawaii 96821
Tel: (808) 377-5471
Fax:(808) 373-2040
Email: registrar@honoluluwaldorf.org