



**DEPARTMENT OF DEFENSE  
DEPENDENTS SCHOOLS  
HEIDELBERG AMERICAN MIDDLE SCHOOL  
Unit 29237  
APO AE 09102**

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

Patient Name \_\_\_\_\_ Birthdate \_\_\_\_\_

I, \_\_\_\_\_ authorize \_\_\_\_\_

to release the following medical information to:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please initial appropriate box:

\_\_\_\_\_ Immunizations only

\_\_\_\_\_ Any and all of my medical records (as of date of release)

\_\_\_\_\_ Any and all of my medical records except for the following:

\_\_\_\_\_ Lab, x-ray, and test results

\_\_\_\_\_ Any record of treatment for drug and/or alcohol dependency or abuse

\_\_\_\_\_ Any record of mental health treatment

\_\_\_\_\_ Any record of testing, care, treatment, reporting or research pertaining with HIV or related diseases.

This information is being released for the following purpose(s) only:

\_\_\_\_\_  
and may not be used for any other purpose or released to any other person(s) without my written consent.

This release is effective for six months from the date of execution, however I may revoke it at any time by providing notice in writing to the above named party.

\_\_\_\_\_  
Parent/Legal Guardian of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness