**CARROLL COUNTY PUBLIC SCHOOLS**

**AUTHORIZATION FOR RELEASE OF IMMUNIZATION RECORDS FOR ADMISSION TO SCHOOL**

**Individual Submitting the Authorization (Parent or Guardian of Student)**

Last Name:_____ First Name:_____ M.I.:_____
Street Address:_____ Apt. #:_____
City:_____ State:_____ Zip:_____
Student Name:_____ Student Date of Birth:___/___/____

**Person Authorized to Disclose Immunization Records**

Provider Name:_____
Name and Title of Individual Disclosing Information:_____
Address:_____
Phone Number:_____

**Person Authorized to Receive Immunization Records**

Name of School:_____
Name and Title of Individual Receiving Information:_____
(School Nurse or Other Individual)
School Address:_____
School Telephone Number:_____

**Signature for Authorization**

I, (name of parent/guardian) _____, authorize the disclosure immunization records for the student specified above for admission to school as required by MD Code Ann., Educ §7-403, to the individuals affiliated with the school as indicated above. I understand that, if the persons or organizations I authorize to receive and/or use the immunization records are not subject to the federal or state health information privacy laws, they may further disclose the immunization records, in which case, it may no longer be protected by the health information privacy laws.

I understand that I may revoke this authorization at any time by giving written notice of my revocation to my provider. In order to obtain a revocation form to revoke this authorization, I understand that I may contact my provider's office. I understand that revocation of this authorization will not affect any action that those named or unnamed herein, took in reliance on this authorization before my provider received my written notice of revocation.

This authorization expires on _____ (No later than end of school year).

Signature (parent or guardian):_____ Date:_____