

REAVIS HIGH SCHOOL DISTRICT #220
AUTHORIZATION FOR RELEASE OF STUDENT HEALTH RECORDS

I hereby consent and request Reavis High School to release Health Records pertaining to:

Student (Print Name): _____

Signature: _____

Maiden Name (If Applicable): _____

Date of Request: _____

Date of Birth: _____

Graduation Year: _____

Phone Number: _____

Mail Health Records To: _____

Fax Health Records To: _____

Please Note:

- *Requests must be in writing, signature required.*
- *Copy of a non expired photo ID for processing mailed or faxed records.*
- *Faxed Health Records will be faxed ONLY to educational institutions.*
- *There is a \$10.00 fee for each copy requested. Cash or Money Order made payable to Reavis High School ONLY. Checks will be returned.*
- *Completed forms should be mailed with fee to: Reavis High School, Attention: Registrar, 6034 West 77th Street, Burbank, Illinois 60459.*

According to the Family Educational Rights and Privacy Act (the Buckley Amendment), it is not necessary to obtain written consent to release records between schools. The Amendment states that school official, including teachers within the educational institution and officials of other school systems, may receive a students records without a written consent for release of records.

Office Use Only – Please do not write in this area.

Health Records Given to Student: : _____

Health Records Faxed to Educational Institution: _____

Health Records Mailed to Address Designated Above: _____