KAMEHAMEHA SCHOOLS

AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION

I hereby authorize the healthcare provider named below to disclose diagnosis, treatment, prognosis and other related information regarding my child for the purpose of informing the provision of available supports and modifications in order to help ensure my child's health and safety while participating in a Kamehameha Schools (KS) program.

I authorize disclosure to and among the following KS employees as necessary to support my child:

- Principal
- Vice Principal
- Dean
- Behavioral Health Specialist
- School Counselor
- Other:_____
- Medical Director
- Clinical Director
- School Nurse
- Athletic Trainer
- Residential Life Staff

I acknowledge that disclosed information, other than related to a substance use disorder, may be redisclosed to other KS employees who have a legitimate educational interest.

This authorization shall remain in effect for the duration of treatment or until the child is no longer a student at KS, whichever occurs first. I understand that I can contact my child's healthcare provider to rescind this authorization at any time.

Patient:_____ _____ _____
Name Date of Birth Grade

Healthcare Provider:_____

Parent/Legal Guardian: _____
Printed Name

_____
Signature

_____
Date