1. Student Information Information **Include Name and Date of Birth for each student**	1._____ 6._____ 2._____ 7._____ 3._____ 4._____ 5._____
2. Release Information From: (***Who*** has the information you want released?)	NAME/ORGANIZATION: Riverwood Healthcare Center Phone 218-927-2121 Address: 200 Bunker Hill Drive Fax: 218-927-5319 City: Aitkin State: MN Zip: 56431
3. Release Information To: (***Where*** do you want the information sent?)	☐ McGregor School FAX #768-3901
4. Purpose of Release: (***Why*** is it needed?)	☐ Notification of COVID test results for return to school

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization expires once the above stated purpose is fulfilled or one year, whichever comes first.

Patient/ Legal Guardian Signature:_____ Date: _____

Authority to act on behalf of patient (attach document) _____