HMONG COLLEGE PREP ACADEMY

1515 Brewster Street, Saint Paul, MN 55108
Office:(651) 209-8002 • Fax:(651) 289-1802
www.hcpak12.org

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

_____ _____/_____/_____
Student's First Name Last Name Date of Birth

_____ _____ _____
Parent/Guardian Name Date Telephone

I authorize Hmong Academy, Health Staff

1515 Brewster St, St. Paul, MN 55108 (Street, City, Zip) 651-209-8004 (Telephone) 651-289-1802 (Fax Number)

To exchange information with:

_____
Clinic/Health Care Provider

_____
Address City, State, Zip

_____
Telephone Fax

The following information is requested:

- ☐ Mental Health History
- ☐ Office/Clinic Visit Notes
- ☐ Other _____
- ☐ Consultation
- ☐ Admission/discharge summary

The purpose for this request is:

- ☐ To provide school personnel with a better understanding of your child's needs
- ☐ To collaborate services

State of Authorization:

- I understand that the authorization takes effect the day that I sign it and expires one year from the date of signature
- I understand that I may revoke this authorization at any time by giving written notification
- It is the practice of HCPA to not disclose records without consent
- A photocopy/fax of this authorization which has not been altered will be treated in the same manner as the original
- Services are not conditioned upon this release of information

_____ _____ _____
Date Signature of Parent/Guardian Relationship to Student