Willowbrook High School
Health Services
1250 S. Ardmore
Villa Park, Illinois 60181

Fax # 630-530-6062

Authorization to Release Immunization Records

Today's Date_____ Month/Year of Graduation_____

Name_____
Last name First Middle

Maiden Name_____ Date of Birth_____

Home Address_____

City_____ State_____ Zip Code_____

Phone Number_____

I _____ authorize District 88, Willowbrook High School,
Signature
to release my immunization information to:

_____
Name

_____
Address

_____
City, State, and Zip Code

_____
(and/or Fax #)

The FERPA/HIPAA Act of 1996 was enacted to improve the efficiency and effectiveness of the education and health care system through the establishment of national standards and requirements for electronic health care transactions and to protect the privacy and security of individual's health information and records.

Office use only
Date sent_____