SAINT THOMAS AQUINAS REGIONAL CATHOLIC HIGH SCHOOL

14520 Voss Drive
Hammond, LA 70401

Phone: 985.542.7662
Fax: 985.542.4010
www.stafalcons.org

To: Physician _____

City _____

Phone Number _____

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

This authorization applies to healthcare information relating to the following injury, condition, treatment or dates:

Patient Name: Patient DOB:

Parent/Guardian Name: Patient SSN:

Injury Information:

This request authorizes you to release and/or discuss private medical records to the St. Thomas Aquinas Athletic Trainer in regards to sports related injuries/illnesses and their treatments.

Information can be faxed to:

Athletic Trainer Vanessa Taromina, 985-542-4010

Parent Signature: _____

Date: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.