PARENTAL PERMISSION TO OBTAIN INFORMATION

I, ____, give consent to the physician,
(Parent/Guardian Name)

hospital, clinic, agency or school specified below to release information concerning the diagnosis and/or

treatment of ____, _________________________,
(Student Name) *(Date of Birth)*

Clinic/Hospital# ___________________________ and/or Medicaid # ___________________________

to the ___________________________________ School District. This information will be used in coordinating the educational program, ancillary therapy and related school health services for this child. This authorization for release of information being requested is effective immediately and shall be valid for one year from the date signed.

Specific information being requested: ____

____

Address of party from whom information is being requested:	**This information is to be released to:**
______________________________ **(Name)**	______________________________ **(Name)**
______________________________ **(Street Address)**	______________________________ **(Street Address)**
______________________________ **(City, State, Zip)**	______________________________ **(City, State, Zip)**

______________________________ ______________________________
(Parent/Guardian Signature) **(Relationship to Student)**

____
(Date)