ASCENSION PUBLIC SCHOOLS
Health Services

PARENT/LEGAL GUARDIAN
PERMISSION TO RELEASE & EXCHANGE CONFIDENTIAL INFORMATION

I hereby authorize an exchange of information to occur between the School Health Services nursing staff of the above department and:

PROVIDER: _____ PHONE: _____

ADDRESS: _____

Regarding health information contained in the record of:

_____ _____
STUDENT NAME DATE OF BIRTH

_____
SCHOOL

I further authorize the APSB School Health Services nursing staff to share any health information pertinent to my child's school progress with school personnel and/or other health care providers to which my child may be referred. **I understand that the information shared may be via phone, fax, and/or mail.**
This authorization is in effect for one calendar year from today: _____.
Date

I consent to release of the above information. I understand that all information, records, and documents received under this release will become part of the school record. I understand that use of this information for any reason other than the expressed reason stated above is prohibited and that disclosure of this information to other parties is strictly prohibited.

I completed this form because I am: (please check one) ( ) Legal Guardian ( ) Parent

_____ _____
SIGNATURE OF PARENT/GUARDIAN DATE

Send Records to:

Name: _____

Address: _____
Street City State Zip Code

Phone: _____ Fax: _____

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