Department of School Health Services
Mansfield Public Schools
Mansfield, Ma.

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 agency and:
NAME: _____PHONE:_____

ADDRESS:_____

Regarding: Any or all information
Specific information regarding:_____

Contained in the record of:

_____ _____
NAME DATE OF BIRTH

_____ _____
OTHER NAMES USED SCHOOL

I further authorize the Mansfield Public Schools 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.

The reason for the disclosure is:
Patient care Medical review Other (specify)_____

This authorization is in effect for one calendar year from today: _____
DATE

I consent to release the above information. 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. This consent is subject to revocation at any time, except to the extent that action has been taken in reliance thereon.

I completed this form because I am: (please check one) client legal guardian parent

_____ _____
SIGNATURE OF PARENT /LEGAL GUARDIAN DATE

Please send records to: _____
NAME

_____
ADDRESS