AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
CAMPBELL COUNTY SCHOOLS

STUDENT'S FULL NAME_____ Date of Birth_____

Address: _____ Social Security Number:_____

_____

Specific type of information being requested:
___History and Physical
___Educational Evaluations
___Speech/Language Evaluations
___Occupational Therapy/Physical Therapy Evaluations
___School Recommendations
___Medical Information that Impacts School Performance (including medications)
___Other:
___Other:
___Other:

The information indicated above shall be disclosed to:

Name_____ Name_____

Agency/School_____ Agency/School_____

Title_____ Title_____

Address_____ Address_____

_____ _____

Phone_____Fax_____ Phone_____Fax_____

This authorization will be valid for the _____school year and may be revoked, in writing, at any time by parent/guardian. It is understood that information disclosed/action taken prior to the revocation cannot be reversed. Any information disclosed will become a part of the student's permanent school record.

I, _____, parent/guardian of student named above, authorize the release of the information indicated above by:

Name/Organization: _____

Address: _____

_____

Phone: _____

to the representative(s) of Campbell County Schools.

Signature_____ Date_____

___Parent ___Legal Guardian ___Student (if of legal age)

Witness_____ Date_____