Clay Community Schools
Health Services
August 1, 2024-June 30, 2025

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION REGARDING:

Name of Student: _____

Date of Birth: ____/____/____ School: _____ Grade: _____

For the purpose of providing appropriate instruction and assistance in school, I hereby authorize Clay Community Schools to ___ obtain, __release, ___exchange specific medical/ psychological records and/. or evaluations concerning the above student with the following:

_____

(Hospital, clinic, physician, institution, association, school)

_____

Address

_____

City, State & Zip *Phone*

_____

Contact Person

_____

I understand that the above information received by Clay Community Schools shall not be released to another agency/person other than the officials of the school collecting or using such information unless written permission is given by the parent, legal guardian, or pupil of legal age of consent (18 years of age or older).
Under the rights given to me by law, I also understand that I may:

1. *Receive a copy of the released information if desired or*
2. *Review the contents of the information in person if I contact the school nurse.*

_____

Signature of person giving consent *Relationship*

_____

Address *City State & Zip*

_____

Phone *Date*

Please return to: _____ fax _____

Address_____ phone_____