Genesee County School Health Services

AUTHORIZATION TO RELEASE INFORMATION

Permission is granted to _____
(Name of Provider)

to release information on _____ DOB: _____
(Student's Name)

to _____
(School Name, Address, Phone Number, Fax Number)

_____
(Attention)

Information to be released:

_____

_____

For the purpose of:

_____

_____

This consent may be withdrawn by written notification at any time before information is released.

Unless withdrawn in writing, this consent expires as follows:

Date _____

Event _____

Condition _____

_____

Parent/Guardian/Client Signature Relationship Date

_____

Witness Signature Date