AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

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GREENE COUNTY SCHOOLS ♦ SCHOOL HEALTH SERVICES ♦ 993 HAL HENARD ROAD ♦ GREENEVILLE, TN 37743
Phone 423-798-2646 ♦ Fax 423-787-0715

STUDENT'S NAME: _____

DATE OF BIRTH: _____

TO: PHYSICIAN NAME AND ADDRESS

_____

_____

_____

I hear-by authorize you to release medical information to be used in the planning of my child's educational program and Individualized Health Plan. Granting this consent is voluntary on my part. I understand that this information will only be released to Greene County School System employees who are directly involved in the educational and health program of my child. I also authorize Greene County School Nurses to discuss my child's health issues with above named physician if necessary. This release is valid for one year from date signed.

I understand and agree to the above statements.

_____
Parent or Legal Guardian

_____
Date

Please sign and return to:

School Health Services
Greene County Schools
993 Hal Henard Road
Greeneville, TN 37743

ATTN: School Nurse

FAX: 423-787-0715