ORANGE SOUTHWEST SCHOOL DISTRICT

24 Central Street
Randolph, VT 05060
Phone: 802-728-5052 Fax: 802-728-4844
Serving the Communities of Braintree, Brookfield and Randolph

MEDICAL INFORMATION RELEASE REQUEST

Regarding Student _____ DOB / /

Purpose of Release:_____

I hereby request and authorize the following information source:

_____

_____

To release information to:

RUHS
15 Forest
Randolph, VT 05060

Portion of the Medical Record to be released

___ Evaluations
___Diagnosis
___Treatment Plans
___Verbal Exchange of Information
___Other:_____
___Substance Abuse Information
___Progress Notes
___Med Checks

Manner in which information is to be released (written, electronic, verbal etc)

_____

I consent the release of the information described above. I may revoke my consent at any time by notifying the source of information specified above in writing.

_____

Signature and Date of Parent/Guardian