



Education Today
Knowledge Forever

HERRICKS PUBLIC SCHOOLS

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Name: _____

DOB: _____

Address: _____

I hereby give: _____

Name of Physician or Medical Facility (Sender of Records)

Address of Physician or Medical Facility

Permission to exchange/send reports and information concerning his/her knowledge of the above named employee; including extent or nature of information to be disclosed:

Medical ()

Social ()

Psychiatric ()

Psychological ()

Other ()

These records can be exchanged with:

Herricks Public Schools

999 Herricks Road

New Hyde Park, NY 11040

(Receiver of records)

I hereby authorize the release of the above information from my records. I understand that the information to be released is confidential and protected from disclosure. I also understand that I have the right to cancel my permission to release information at anytime before it is released.

Name of Authorizing Person

Signature

Date