South Amboy Middle/High School

200 Governor Harold G. Hoffman Plaza
South Amboy, New Jersey 08879

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Consent for Release of Confidential Information

Date: _____ Student Grade: _____

Student Name: _____ DOB: _____

Student Address: _____ South Amboy, NJ 08879.

Parent/ Guardian Name (s): _____

Home Phone: _____ Cell Phone: _____

I certify that I am the parent/ guardian of _____ and I authorize the release of any and all information as it pertains to my child's physical health, mental health, social/ emotional health and any other factors that may assist in determining the best help and coordinated care at school for the child.

Parent/ Guardian Signature (s): _____ Date: _____

Parent/ Guardian Signature (s): _____ Date: _____

*** Please list names and phone numbers of those practitioners or clinicians who serve or work with your child.

☐ Check here if the release is for a nonspecific provider/ providers.

Name of Provider: _____

Provider's Profession or Professional Title _____

Phone Number: _____

Location or Practice Name: _____

Confidential Information