



ST. JAMES
PARISH SCHOOLS
Inspiring Hope and Purpose

Department of School Health Services

PARENT/LEGAL GUARDIAN PERMISSION TO RELEASE & EXCHANGE CONFIDENTIAL INFORMATION

I hereby authorize an exchange of information to occur between the School Health Services nursing staff of the above agency and:

PHYSICIAN/CLINIC NAME: _____ PHONE: _____

ADDRESS: _____

Regarding health information contained in the record of:

STUDENT NAME DATE OF BIRTH

SCHOOL

I further authorize the SJPSB School Health Services nursing staff to share any health information pertinent to my child's school progress with school personnel and/or other health care providers to which my child may be referred. **I understand that information shared may be via phone, fax, mail, and/or email.**

This authorization is in effect for one calendar year from today: _____
DATE

I consent to release of the above information. I understand that all information, records, and documents received under this release will become part of the school record. I understand the use of this information for any reason other than the expressed reason stated above is prohibited and that disclosure of this information to other parties is strictly prohibited.

By signing, I certify that I have completed this form and I am the Parent/Legal Guardian:

SIGNATURE OF PARENT/LEGAL GUARDIAN DATE

Records can be sent to:

Email: nurses@sjpsb.org or Fax: 225-258-8112