Ayer Shirley Regional School District

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AUTHORIZATION TO RELEASE/OBTAIN MEDICAL RECORDS

I _____, HEREBY AUTHORIZE THE RELEASE/OBTAINING OF MEDICAL INFORMATION/RECORDS FOR THE FOLLOWING STUDENT:

Student's name:_____

Date of Birth: _____

Release to/Obtain from:
(Please provide the providers name, address, telephone number and fax number)

_____
_____
_____
_____
_____
_____
_____

This release is valid for 1 year from the date of signature.

Parent Signature:_____

Nurse Signature:_____

Date:_____