Frankfort-Schuyler Central School District

Authorization for Release of Information

Students Name: _____ Students Date of Birth: _____

Address: _____

Parental/Guardian Consent

Parental/Guardian Name: _____

I hereby authorize the following person(s)/organization(s) to provide to, and receive from, Frankfort-Schuyler Central School District information on the above named person:

Please Select: WRITTEN ( ) VERBAL ( ) BOTH WRITTEN AND VERBAL ( )

( ) Counseling Agency: _____

( ) Medical Provider: _____

( ) Service Provider: _____

( ) Other Provider: _____

This information will be utilized to provide medical services, coordinate medical services, coordinate services with my family/concerned person and coordinate educational planning programs with school personnel

Authorization

I understand that I will not need to consent to the release of information in order to obtain services. I choose to do so willingly and voluntarily for the purposes specified above. The duration of this authorization is for no longer than the school year ending in _____ unless I specify a date, event, or condition upon which will expire sooner. I understand that I may revoke this consent at any time by notifying the school is writing, except to the extent that action has been taken in reliance on my consent

Signature of Parent/Guardian _____

Date: _____