Farmington Municipal Schools Health Services
Official Release of Confidential Information

Date: _____

Student Name: _____ DOB: _____

I hereby authorized Farmington Municipal Schools to:

- ☐ Obtain information from
- ☐ Release information to
- ☐ Exchange information with

The agency listed below regarding the above-named student. This release will be in effect for one year from the date above. Information regarding the above-named student is needed as soon as possible to assist in determining appropriate educational services. This consent may be revoked at any time with written notice.

Signed:

_____ _____

Parent/Guardian/Surrogate Student, if over age 14

_____

School Personnel

School, Agency, Individual:

_____

Name/Agency

_____

Address

_____

_____

_____

Telephone/Fax

Information to be Disclosed/Released:

- ☐ Educational Records, Inclusive of Special Education
- ☐ Psychoeducational Evaluations
- ☐ Medical Records
- ☐ Psychiatric/Psychological Records
- ☐ Discharge Summary
- ☐ Treatment Plan
- ☐ Other _____

Please Send Information to:

_____

Name of School Nurse

_____

School Name

_____

School Address

_____

City/State/Zip

_____

Telephone/Fax

Revised: 03/2022