Glens Falls City School District

Authorization for Release of Confidential Information

I hereby consent to and authorize Glens Falls City School District to obtain from and/or release to:

____
Name of Child's Pediatrician

____
Address/City/State/Telephone/Fax

The following information pertaining to:

____
Child's Name

____
Child's DOB

The information to be disclosed is:

-Educational Evaluations/Reports

-Medical Evaluations/Reports

-Psychological Evaluations/Reports

-Medical history and physical examination

-Diagnosis, brief description of progress and prognosis

-Immunization Records

This information is needed for the following purposes:

-To provide ongoing treatment/continuing care

-To coordinate treatment efforts with parent/guardian

-To coordinate educational planning

-To coordinate services with authorized school officials and/or community service providers

I understand that I have the right to revoke this authorization at any time by submitting a request in writing. The revocation will not apply to information that has already been released in response to this authorization. This authorization will expire in one year from the date of the signature below and may be used until such time for either a one-time release or a periodic release of information. I understand that disclosure of this information is voluntary. I understand that I have a right to receive a copy of this authorization. The duration of this authorization is for no longer than one (1) year unless I specify a date, event or condition upon which it will expire sooner. Rerelease of this information without written consent is prohibited.

____
Parent/Guardian Signature

____
Date