SCHOOL HEALTH SERVICES
WAPPINGERS CENTRAL SCHOOL DISTRICT

_____ SCHOOL

AUTHORIZATION FOR RELEASE OF RECORDS AND INFORMATION

To whom it may concern:

I hereby authorize the release of copies of scholastic records; medical, psychiatric/psychological reports; abstracts and information pertaining to:

Name: _____

Address: _____

_____

Date of Birth: _____

This information is to be directed to the attention of the following named person:

Name: _____

Address: _____

_____

Signed: _____ Date: _____

Address: _____

_____