Authorization to Release/Obtain Healthcare Information

Name: _____

Date of Birth: _____

Address: _____

Parent/Guardian: _____

I authorize personnel from Shawsheen Valley Technical High School to release/request information from:

Agency: _____

Contact Person: _____

Address: _____

Phone/Fax/Email: _____

I understand that I may revoke this authorization at any time by submitting a written request to the Shawsheen Valley Regional Technical Vocational School District. This consent will otherwise expire one year from the date signed. I understand that this revocation will not apply to information that has already been released pursuant to this authorization.

Parent/Guardian Name (print): _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Margaret Joyce, RN, BSN
School Nurse
Shawsheen Valley Technical High School
Phone: 978-671-3625
Fax: 978-671-3649