CHAMBERSBURG AREA SCHOOL DISTRICT
SCHOOL HEATLH SERVICES
AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

TO: _____ DATE: _____
_____
_____
_____

The Chambersburg Area School District is authorized to receive from/release to _____ the following information:

___Medical/Immunization Information
___Health/Dental Records
___Hospital/Clinic Data
___Telephone Consultation
___Home/School Visitor Reports
___Counseling Reports
___Psychological Evaluations
___Psychiatric Evaluation
___Speech/Hearing Evaluations
___Work Evaluations
___Audiological Evaluations
___Other_____
_____
_____

The information will be used for the purpose of coordinating health needs with the educational program.

This consent shall begin on _____and end on_____.

This information is being disclosed from records whose confidentiality may be protected by the Pennsylvania Law, Act 63 and/or Pennsylvania PL 817 and/or Federal Public Law 93-282. These regulations prohibit the receiving agency from making any further disclosure of this information without prior written consent. **When records are requested by school personnel for a student who has enrolled or is enrolling in a school system, parental permission is not required.**

Child's Name_____ DOB_____ Grade___

Address_____

Parent/Guardian Signature_____ Date_____

PLEASE FORWARD RECORDS TO: School Health Services
_____
_____
_____

PHONE:_____ FAX:_____E-MAIL_____