KAPS HEALTH SERVICES: CONFIDENTIAL INFORMATION RELEASE

Student Name: _____ **DOB:** _____ **Sex:** _____

Please authorize:

(Name) _____

(Address) _____

(City,State,Zip) _____

(Phone) _____

To Release Confidential Records regarding above named student:

☐ Medical _____

☐ Psychological _____

☐ Other _____

Email To: SSO@kapschool.org, Attention: School Nurse

These records will be used to assist school personnel in determining an appropriate health/medical program for your child.

◯ Yes ◯ No I have been fully informed and do understand the school's request for my consent for the release of my child's records, as indicated above. This information will be released upon receipt of my written consent.

◯ Yes ◯ No I understand that my consent is voluntary and may be revoked in writing at any time.

Parent/Guardian Signature: _____ Date: _____