CLARK COUNTY PUBLIC SCHOOLS
AUTHORIZATION FOR RELEASE OF INFORMATION

1. The undersigned hereby authorizes:

_____
Service Provider Name (physician, therapist, etc. NOT school)

_____

_____
Address

To release information from the academic/medical record of:

_____ _____
Student Name I.D. Number

_____ _____
Birth-date Dates of Treatment/Service

2. Information to be released to (Person/Agency Address):

____Clark County Public Schools_____

____1600 W. Lexington Ave. Winchester, KY 40391_____

3. Type of information to be released:

medical information/records_____

_____

4. Purpose for release:

education planning/student support services_____

_____
Date Signature of Parent/Guardian

_____
Relationship to Student