

RELEASE OF INFORMATION AUTHORIZATION FORM

WILLIAMSBURG SCHOOLS
1 Petticoat Hill Road
Williamsburg, MA 01096
Phone: (413) 268-8421
Fax: (413) 268-8420

HEALTH OFFICE
Phone: (413) 268-7345

I authorize my child's healthcare provider/office staff: (name, address, phone)

To release health information to: -----

Regarding: _____ DOB: _____
(student's name)

To disclose the following protected health information: (check all that apply)

- Medication order
- Physical examination
- Immunizations
- Special healthcare instructions
- Requested health information noted in comment area*
- Restrictions during school hours
- Notes from last office visit/labs

*Comment area: -----

This authorization will be in effect for one calendar year from this date _____ unless
revoked in writing to Williamsburg Schools.

Signature of Parent/Guardian

Date