HEALTH OFFICE
CAMBRIDGE CENTRAL SCHOOL
24 SOUTH PARK STREET
CAMBRIDGE, N Y 12816
518-677-8527 ext. 1428

RELEASE TO EXCHANGE CONFIDENTIAL MEDICAL INFORMATION

I hereby authorize you to exchange information regarding ______________________,
(Student's name)
to include the most recent physical exam and immunization record. Any information you would like restricted list here: ________________________________
____

This authorization will be in force and effect in preparation for and throughout your child's education at Cambridge Central School or until ____________________.

This authorization may be revoked in writing at any time.

The information may be exchanged between Cambridge Central School Staff and

Physician's Name ______________________________

____

Address ______________________________

____

Telephone Number______________________________

This release has been authorized by:

Signed ______________________________

Relationship ______________________________

Date ______________________________