Parent/Guardian
PERMISSION TO RELEASE HEALTH RECORDS

Student: ____**Birth Date:** ____________________________

School: ____ **Grade:** ________________________

I give permission to release health records on my child to the following agencies for the benefit of meeting his/her health care needs.

Washington County School District Attention: ____________________________________ Fax Number: _________________________________ 121 West Tabernacle St. George, Utah 84770
Health Care Provider:_____________________________ Fax Number:_____________________________________ Address:____ City:____ Zip Code:____
Other: ____ ____ ____ ____

RECORDS TO BE RELEASED:

Exchange of information for health care planning which could include medication information, medication authorizations, medical history, immunization records and/or physician consult.

Other:____

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Parent/Legal Guardian Signature: ____ **Date:** _______________

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