Dear Parents and Guardians,

In an effort to aid in receiving health records (immunizations, most recent physical, and treatment records) from physician's offices, this notice is being sent home to allow the school health office to obtain records directly from primary care providers. My goal is to increase communication between primary care providers and the school's health office to assist in any needed services. If you have any questions, please feel free to contact me at 464-1290.

Thank You,
HeatherAnn LaBier, RN,BSN
District Nurse

HILLSBORO-DEERING SCHOOL DISTRICT

AUTHORIZATION TO RELEASE AND EXCHANGE MEDICAL/HEALTH INFORMATION

Date: _____

Student Name: _____DOB: _____ School: _____

Parent/Legal Guardian Name: _____ Phone: _____

Street: _____City: _____ State: _____Zip: _____

I authorize the release/exchange of the following health information between Hillsboro School District and the following Healthcare Provider: (**Please check all that apply**)

☐ bol/Sport Physical Form ☐ Immunization Records ☐ Outpatient Office Notes ☐ Other_____

Name of Healthcare Provider:_____

Address: _____ Phone: _____

and

Hillsboro Deering High School 12 Hillcat Drive Hillsboro, NH 03244 Phone: 603-464-1130

Person Requesting Exchange: ***HeatherAnn LaBier, RN,BSN*** Title: *School Nurse* Phone: ***464-1290***

☐ I give my permission to have information on my child released as indicated above.

☐ I refuse permission to have information on my child released as indicated above.

☐ I would like to talk to someone at the school before making my decision.

Signature (parent/guardian): _____Date:_____

Authorization expires one year from the date of consent unless otherwise specified