Dear Parents and Guardians,

Signature (parent/guardian): ___

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

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 o the following Healthcare Provider:			lillsboro School Dis	trict and
ol/Sport Physical Form Immunization	n Records Outpatient Office No	tes Other		
Name of Healthcare Provider:				
Address:		Phone:		
	and			
Hillsboro Deering High So	chool 12 Hillcat Drive H	illsboro, NH 032	244 Phone: 603-4	64-1130
Person Requesting Exchange:	HeatherAnn LaBier, RN,B	BSN Title: School	ol Nurse Phone: 46	4-1290
I give my permission to have informat I refuse permission to have informat I would like to talk to someone at the	ion on my child released as indi	cated above.		

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

Date: