



Nazareth Area School District DISTRICT OFFICE

One Education Plaza · Nazareth, Pennsylvania 18064-2397
Telephone (610) 759-1170 · Fax (610) 759-8907

Authorization To Release/Furnish Information

I, _____ hereby authorize _____
Name of Parent or Legal Guardian *Name*

of _____
Street Address *City* *State* *Zip*

to release information regarding my child, _____
Name of Student

to _____ Nazareth Area School District _____ or to communicate verbally

with the above-mentioned person for the purpose of _____

The information, which may be released, includes:

- | | | | |
|--------------------------|-------------|--------------------------|---------------|
| <input type="checkbox"/> | Medical | <input type="checkbox"/> | Psychological |
| <input type="checkbox"/> | Academic | <input type="checkbox"/> | Case History |
| <input type="checkbox"/> | Psychiatric | <input type="checkbox"/> | Other: _____ |

I understand that my authorization shall remain effective for a period of one (1) year from the date of my signature and that all information released will be handled confidentially. I also understand that I may revoke this authorization (except to the extent that action has been taken in reliance thereon) at anytime by written, dated communication. It is my understanding that I am not obligated to disclose any information if I do not wish to do so. I permit a copy of the authorization to be used in lieu of the original.

I certify that the meaning of the authorization has been explained to me and that I agree to its terms.

Signature of Parent

Signature of Student (If over 14)

Printed Name of Parent

Printed Name of Student

Date

Date