The Public Schools of Brookline

Brookline, Massachusetts

SCHOOL HEALTH SERVICES

AUTHORIZATION FOR RELEASE OF INFORMATION

Date: _____

TO: _____

_____

_____

Name of Student: _____

Date of Birth: _____

I hereby grant permission to release information of:

_____

_____

_____

_____

_____

to/from the Brookline School Health Services.

Signed: _____

Relationship to Student: _____