# Consent for Release of Information

**Mount Anthony Union High School**
**301 Park Street**
**Bennington, VT 05201**
**802-447-8611**
**FAX-802-442-1284**

I authorize_____
To disclose and receive pertinent medical, educational, social, or mental health records, x-rays and/or screening reports for the purpose of providing evaluation or services to Mount Anthony Union High 301 Park Street Bennington, Vermont 05201. When you return the released information, please send it to the attention of _____
(name)

The above communication is regarding_____
(name of student)

_____
(date of birth)

This information will be protected according to the Health Insurance Portability and Accountability Act (HIPAA) and the Family Education Rights Privacy Act (FERPA) rules.

_____ _____
(signature of parent or legal guardian) (date)

_____ _____
(printed name) (relationship to student)

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( witness- signature and title)

This release will expire one year from date signed unless otherwise specified_____