Livingston
PUBLIC SCHOOLS

AUTHORIZATION FOR THE RELEASE OF INFORMATION

I, _____, hereby authorize:
Parent/Guardian Name or ***Adult Age Student Name***

LIVINGSTON PUBLIC SCHOOLS
11 FOXCROFT DRIVE
LIVINGSTON, NEW JERSEY 07039
Telephone # (973) 535-8000

- ☐ To **RELEASE** information (including, but not limited to medical, psychiatric, psychological, educational)
- ☐ To **RECEIVE** information (including, but not limited to medical, psychiatric, psychological, educational)
- ☐ To **RECEIVE AND RELEASE** information (including, but not limited to medical, psychiatric, psychological, educational)

Regarding: ***Name of Student:*** _____

Date of Birth: _____

TO / FROM:

Name of Therapist, Agency, Physician, School, etc.
Address
Phone Number

Purposes for which this information is to be used:

_____

Specific information to be released:

_____

This authorization shall become effective immediately and shall be valid until the date of:

_____

_____
Parent/Guardian Signature or Adult Age Student Signature Date

I understand that medical/psychiatric information is to be released only to the above named party or agency and may not be further disclosed, except where specifically required or permitted by law, without additional authorization.