



# School Information Release

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Patient name: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Patient's school: \_\_\_\_\_

## Authorization

- I authorize the release of school information to Dr. Alena Ashenberg.
- I give permission for Dr. Ashenberg and any employee of my child's school to discuss my child.

## Signature

Parent/Guardian signature (if student is under 18):

\_\_\_\_\_

Date: \_\_\_\_\_

Patient signature (if 18 or older):

\_\_\_\_\_

Date: \_\_\_\_\_