

**Edwards-Knox Central School  
School Nurses Office  
Phone: 562-8326 ext. 518/ fax: 562-3698**

**AUTHORIZATION FOR EXCHANGE OF CONFIDENTIAL INFORMATION**

Student Name \_\_\_\_\_ Birth Date \_\_\_\_\_

School District \_\_\_\_\_

I hereby authorize the exchange of confidential information between the Edwards-Knox Central School District and the agency/person(s) listed below:

_____ Name of School/Person	_____ Name of Agency/Person
_____ Street Address	_____ Street Address
_____ City, State, Zip Code	_____ City, State, Zip Code

Check all appropriate:

- Health Records
- Psychological and Counseling Records
- Special Education Records
- Transcripts
- Other (specify) \_\_\_\_\_

I understand that the information obtained will be treated in a confidential manner and will not be transmitted to a third party without my permission. This information may be shared with school personnel as needed for the well being of my child. I also understand that it is my right to request a copy of all information and contest any information I feel is incorrect.

_____ Parent/Guardian Signature	_____ Date
_____ Street Address	_____ City, State, Zip Code

**This agreement is valid for the duration of the school year.**