Manchester Health Department
1528 Elm Street
Manchester, NH 03101
Tel: 603-624-6466 / Fax: 603-624-6584

School Name: _____
Grade: _____
School Fax: _____

PERMISSION TO RELEASE
& EXCHANGE CONFIDENTIAL INFORMATION

I hereby authorize an exchange of the information listed below between the staff of the Manchester Health Department and:

Provider/Organization Name: _____ Phone: _____

Provider Address: _____ Fax:_____

Information to be exchanged: Medical Conditions Immunizations Physical Exam(s)
TB diagnostics Lead Results Hemoglobin / Hematocrit Results

Other: _____

_____

Name of client: Date of birth

_____

Other name(s) used: Address (School if applicable)

I consent to the release of the above information. I further authorize the Manchester Health Department staff to share any health information (including diagnosis and treatment) pertinent to the above client's progress with health care providers and / or school personnel to which I or my child may be referred. I understand this release may be revoked at any time with a written request to the above. I understand I may request a copy of this signed release.

I completed this form because I am: (please check one)

☐ Parent ☐ Legal Guardian ☐ Client (over 18 years of age)

_____

Signature of Client/Legal Guardian/Parent **Date**

This authorization is in effect for current year: _____
Date

Please send records to: _____
Attention: _____
_____
_____