P.O. Box 192 21187 NY 22
Hoosick Falls, NY 12090
Phone: (518) 686-7012
www.hoosickfallscsd.org

CONSENT FOR RELEASE OF MEDICAL RECORDS

Name: _____ Date: _____

Birthdate: _____

In regard to the above named individual, I hereby give consent to:

_____, to release all medical records relating to
(Physician's Name)

concussion, head injury, or seizure of the above listed student. Records may be sent to the Hoosick Falls Central School District's School Physician at:

Dr. Marcus Martinez, M.D.
21 1/2 Parsons Avenue
Hoosick Falls, NY 12090
(Telephone: 518: 686-5300 Fax: 518: 686-8800)

_____

Parent/Guardian Signature

Cc: Jane Conte, School Nurse