

Sandman Consolidated School
838 Seashore Road
Cape May, NJ 08204
Telephone: (609) 884-9410
Fax: (609) 884-9412

LOWER TOWNSHIP ELEMENTARY SCHOOL DISTRICT
834 SEASHORE ROAD
CAPE MAY, NEW JERSEY 08204

Memorial School
2600 Bayshore Road
Villas, NJ 08251
Telephone: (609) 884-9430
Fax: (609) 886-0313

Maud Abrams School
714 Towabank Road
Cape May, NJ 08204
Telephone: (609) 884-9420
Fax: (609) 884-9421

TELEPHONE: (609) 884-9400
FAX: (609) 884-1821

Carl T. Mitnick School
905 Seashore Road
Cape May, NJ 08204
Telephone: (609) 884-9470
Fax: (609) 898-9481

RELEASE OF INFORMATION

Student Name: _____ Birth Date: _____
I authorize: _____ to Release Information
specified below to:

This release of information _____ IS _____ IS NOT a reciprocal Release of Information.
Information requested includes: _____

The purpose and need for such disclosure _____

This authorization shall remain in effect until _____ or until _____

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

Signature of Parent:

Date

If the authorization is signed by a personal representative of the student, a description of such representative's authority to act for the patient must be provided