HOLY SPIRIT
CATHOLIC SCHOOL

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I, _____, parent of _____
Please PRINT name MINOR Child's name

Do hereby authorize: _____
Name of Primary care provider/therapist

_____
Address & contact information (phone & fax #/email)

to release any information about my child's personal, emotional, behavioral, social and academic records.

I hereby affirm that I am the biological and/or legal guardian of:

Name:_____ DOB:_____
PRINT Child's name

I hereby release Holy Spirit Catholic School and its employees from all ***legal responsibility and liability*** that may arise from authorized acts.

This authorization is in effect for the ***current school year ONLY.***

_____ _____
Signature of Parent/Guardian Date

_____ _____
Signature of Parent/Guardian Date

_____ _____
Signature of Counselor Date

_____ _____
Signature of Teacher Date

_____ _____
Signature of Administrator Date