The Marshall School

PERMISSION TO RELEASE
CONFIDENTIAL INFORMATION

Permission is hereby given to The Marshall School to request clinical information and/or test results for:

Student Name: _____

The Marshall School may receive from, or send to:

Physician	Teacher
Name: _____	Name: _____
Address: _____	Address: _____
City/State/Zip: _____	City/State/Zip: _____
Phone: _____ Fax:_____	Phone: _____ Fax:_____

Signature:

_____ Date _____

Relationship:

_____