GRISWOLD HIGH SCHOOL
HEALTH OFFICE RECORDS RELEASE FORM

Name_____

Address_____

Phone Number_____

Birth Date ____/____/____

Year of Graduation_____

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Where would you like the record(s) sent:

Name_____

- Fax # ( )_____
- Email_____
- Address_____

_____

I hereby give permission for the release of my health record(s)

_____ _____
Name Date

_____ _____
Signature (Parent if under age 18) Date

Please mail this to: Griswold High School, Attn: Health Office, 267 Slater Ave, Griswold CT 06351 or Fax (860) 376-7677