# *Woodstown-Pilesgrove Regional School District*

**135 East Avenue, Woodstown, NJ 08098**

**Virginia M. Grossman**
Superintendent of Schools
(856) 769-0144, Ext. 22252
Fax: (856) 769-4549

**Rose Wang Chin**
Business Administrator
(856) 769-0144, Ext. 22251
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Student Name: (print)_____ Date of Birth: _____

Parent/Guardian Name: (print)_____

I authorize the release of medical information pertaining to the above student to Woodstown Pilesgrove Regional School District from the following Physician or clinical office(s).

1.)

_____
(Physician's name and Organization)

_____
(Physician's Address)

_____
(Physician's phone) (Physician's Fax)

2.)

_____
(Physician's name and Organization)

_____
(Physician's Address)

_____
(Physician's phone) (Physician's Fax)

This letter hereby gives permission to Woodstown Pilesgrove Regional School district to obtain medical information relating to _____ from the dates of _____ - _____.

**Expiration of authorization**
This authorization expires in 180 days from the date of signature.

_____
Signature of Parent/Guardian Date

_____
Witness of Signature Date