STUDENT CRISIS INTERVENTION TEAM
PERMISSION FOR RELEASE OF RECORDS

TODAY' S DATE: ______________________ SCHOOL: __________________________

SCHOOL ADDRESS: ____

PHONE #: ____________________ FAX#:________________________________

TO: ____
SCHOOL NURSE NAME

I hereby give permission to **ST. JOSEPH HOSPITAL MEDICAL CENTER** to release /request records pertaining to my son/daughter:
______________________________________(Print name clearly)

The following items should be sent to the school nurse at ________________________ in the
(Identify School)
Passaic Public Schools Division of Student Advocacy:

- ______Lab Reports
- ______Psychiatric Evaluations if available
- ______Face to face Evaluation
- ______Discharge Summary
- ______Psychiatric Review
- ______Other (Please Specify)

DATE OF TREATMENT SERVICE: __________________________________

Signature of Parent: ____

Make sure one copy is on file in school and the parent has one to take to the hospital. Remind the parent we need one of the items above for readmission to school.