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## SCHOOL INFORMATION RELEASE FORM

School Name: \_\_\_\_\_ Date: \_\_\_\_\_

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Phone Number: \_\_\_\_\_

\_\_\_\_\_ I authorize to release any school information to Dr. Alena Ashenberg

\_\_\_\_\_ I give permission for any school employee to discuss my child \_\_\_\_\_  
with Dr. Ashenberg, and give Dr. Ashenberg permission to discuss him/her as well.

\_\_\_\_\_  
Signature of Parent/Guardian (if student is under 18)

Date \_\_\_\_\_

\_\_\_\_\_  
Signature of Student (if student is 18 or older)

Date \_\_\_\_\_