New Castle Area School District
Authorization for the Release of Testing/Medical Information

EMPLOYEE INFORMATION:

First Name: _______________ Middle Name: ___________ Last Name: ________________

Address: ____

Social Security Number: ____________________ Date of Birth: ________________________

I hereby authorize my doctor, hospital, treatment facility, drug or alcohol testing facility, or laboratory; to whom assigned a photo or original copy of this authorization/consent form is delivered; to furnish to the New Castle Area School District, Superintendent's Office, 420 Fern Street, New Castle, PA, any information, reports, or copies of records, testing results, or other information concerning the same which may be requested by said office.

I understand and acknowledge that this may include treatment for alcohol/drug abuse and or test results or diagnosis. This consent is subject to revocation at any time to the extent the action has been taken thereon. This authorization and consent will expire one year from the date of the authorization written below. I understand that the recipient of my health information may be charged for the services of releasing medical information; these costs may be transferable to me.

____ ________________________________
Signature of Employee Date Signed

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Printed Name of Employee