Benjamin Franklin Elementary
Mathematics and Science School

Nichelle Logan-Jones, M.Ed., Principal
Patrice Joseph, M.Ed., Principal

Form SS-3

Legacy of Excellence Board (LOE)

CONSENT TO RELEASE BEHAVIORAL HEALTH INFORMATION

(Including Paper, Oral, and Electronic Information)

Your written consent allowing communication between your outside behavioral health provider and Benjamin Franklin Elementary is required by law (La. R.S. 17:173(h)). Please complete all blanks below.

Student Name	Date of Birth
Street Address	City/State/Zip
School	Grade

I hereby authorize:

STREET ADDRESS:_____

CITY/STATE/

ZIP:_____ PHONE NO.:

_____

To Release Protected Medical and Behavioral Health Information To:

NAME: Department of Student Support Services
Legacy of Excellence 1116 Jefferson Avenue
New Orleans, LA 70115 Phone: (504) 304-3932

I authorize and consent to the release of protected medical and behavioral health information related in any way to the behavioral health provider evaluation and services rendered to my child while at school during the school day, including medical history, medications, examinations and reports, hospital records, treatment records, progress reports, and any and all other information directly or indirectly pertaining to my child's identified behavioral health needs.

This authorization and consent shall expire at the end of the current school year.

_____	_____	_____
Printed Name of Parent/Guardian	Parent/Guardian Signature	Date

For Office Use Only:

Name: _____ Date: _____ Time Received:_____

Witness: _____