



**Benjamin Franklin Elementary  
Mathematics and Science School**  
*Charlotte L. Matthew, M.Ed., Principal*  
*Nichelle Logan-Jones, M.Ed., Assistant Principal*  
*Patrice Joseph, M.Ed., Assistant 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: \_\_\_\_\_

Legacy of Excellence c/o Tradonya Domingue  
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: \_\_\_\_\_