AUTHORIZATION TO RELEASE RECORDS

Student Name: _____

Date of Birth: _____

To: _____
(Name of school, doctor, therapist or services provider)

_____
(Address)

_____
(Phone) *(Fax)*

As parent/guardian of above named minor child, I authorize the release and exchange of confidential educational materials, medical records, diagnoses, psychological evaluations, special education records and other information between_____School and_____to be used to support my student's educational needs. I also give permission for verbal exchange of information.

I hereby approve the release of information as indicated above. A copy of this authorization shall be deemed as original. I may revoke this authorization in writing at any time. Such revocation may not be retroactive.

_____ _____
Printed Name of Parent or Guardian *Relationship*

_____ _____
Signature of Parent/Guardian *Date*

Please send information to:

Staff Member:_____

School: _____

Street Address:_____

City, State, Zip: _____

Tel:_____

Fax:_____