AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

School Name _____

Address _____

Email _____ **Phone** _____ **Fax** _____

This form cannot be used for the re-release of confidential information provided to the school by other individuals or agencies. Such requests should be referred to the original individual or agency.

I _____authorize _____ to

_____ release to:

Name: _____
Address: _____
Phone: _____

_____ exchange with:
Name: _____
Address: _____
Phone: _____

the following information pertaining to my child:
_____ academic information/classroom performance/behavior
_____ treatment summary
_____ history/intake
_____ diagnosis
_____ psychological test results
_____ psychiatric evaluation/medication history
_____ dates of treatment attendance
_____ other (specify) _____

for the purpose of:
_____ academic planning (ISP)
_____ evaluation/assessment and/or coordinating treatment efforts
_____ other (specify) _____

This consent will automatically expire one (1) year after the date of my signature as it appears below, or on the following earlier date, condition, or event _____ _____. (See back for authorization extension).

I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released).

_____ _____
Name of Child/Student Date of Birth

_____ _____ _____
Signature of Parent/Guardian Date Cell

RECORD OF AUTHORIZATION EXTENSIONS

I hereby confirm that I have reviewed this consent form and agree to its extension for an additional:

Check One:

_____ school year OR
_____ other (specify) _____

_____	_____	_____	_____
Parent/Guardian	Date	Witness	Date