# PARENT/GUARDIAN CONSENT
# FOR RELEASE OF INFORMATION TO SCHOOLS

Student _____ DOB: _____

School _____ Teacher/Grade: _____

I hereby authorize _____ and:

(Agency or Individual) _____

(Address if known) _____

(Phone number if known)_____

(Fax number if known) _____

to exchange information about the above-named student, for the purpose of contributing to individual health and/or educational planning for student. Specific information to be released is checked below.

_____Educational/IEP/504

_____Medical

_____Occupational Therapy

_____Physical Therapy

_____Psychological

_____Counseling

_____Speech/Language

_____Other (specify): _____

_____

_____

*I understand that the information to be exchanged will not be released to other agencies without my prior written consent. Information within the physician office is protected under HIPAA confidentiality guidelines and in the schools is protected under FERPA confidentiality guidelines. I also understand that I may revoke this authorization at any time.*

_____ _____

(Parent/Guardian Signature) (Relationship to Student)

_____ _____

(Witness Signature) (Date)

_____

(Expiration Date)

Original to Nurse