Revised: 3/29/10

EDUCATIONAL SERVICE UNIT #8

RELEASE FORM

Information Request

I/we hereby authorize the release of information to Educational Service Unit #8 Special Education Department and _____ Public School from any physician, hospital, school, clinic, agency or institution having medical, psychological, school or social records.

I/we authorize the release of information from Educational Service Unit #8 Special Education Department and _____ Public School to any physician, hospital, school, clinic, agency or institution involved in the educational or physical well being of this child.

A photocopy of the signed authorization for release of information shall be as valid as the original. This release may be revoked at any time up to the date of release of information, and in any event, expires one (1) year after date of signature.

Child's Name: _____

Signature: _____ Date: _____
(Parent(s)/Guardian(s)

Witness: _____ Relationship: _____

Please send information to:

Name: _____

Address: _____

_____

_____

Phone: _____