Educational Service Unit 8
Authorization for Exchange of Student Records/Information

Child/Student Name: _____

Date of Birth:_____

I hereby authorize _____
Agency/Provider Name

_____
Agency/Provider Address

_____
Agency/Provider Phone Number

and ESU 8/_____ Public School to exchange health and education information/records for the purpose of educational or medical evaluation, program planning, and providing services and treatment. This consent shall be valid as long as the student is attending _____ Public School. I authorize information release as specified below:

- ☐ School Records (most recent transcript)
- ☐ Standardized Achievement test results
- ☐ Physician's History/Visit notes/Diagnoses
- ☐ All of the Above
- ☐ Other:_____
- ☐ Progress Report/Notes
- ☐ Counseling Records
- ☐ Health/Immunization Records

Communication may be written and/or verbal

Signature:_____ Date: _____
Parent/Guardian/Adult Student

Relationship to Child:_____

Please send information to:

_____

_____

_____