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:

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☐ School Records (most recent transcript) ☐ Progress Report/Notes

Top of Form

☐ Standardized Achievement test results ☐ Counseling Records

Top of Form

☐ Physician's History/Visit notes/Diagnoses ☐ Health/Immunization Records

Top of Form

☐ All of the Above

☐ Other:_____

Bottom of Form

Communication may be written and/or verbal.

This authorization will expire on _____ or one year from the signed date. Revised 4/20

Signature:_____
Parent/Guardian/Adult Student

Date: _____

Relationship to Child:_____

This authorization will expire on _____ or one year from the signed date. Revised 4/20