



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:

- | | |
|--------------------------------------------------------------------|----------------------------------------------------------|
| <input type="checkbox"/> School Records (most recent transcript) | <input type="checkbox"/> Progress Report/Notes |
| <input type="checkbox"/> Standardized Achievement test results | <input type="checkbox"/> Counseling Records |
| <input type="checkbox"/> Physician's History/Visit notes/Diagnoses | <input type="checkbox"/> Health/Immunization Records |
| <input type="checkbox"/> Behavior Plans, Documentation, Data | <input type="checkbox"/> Special Education Documentation |
| <input type="checkbox"/> Staff Summaries or Documentation | <input type="checkbox"/> Psychological Testing |
| <input type="checkbox"/> Other: _____ | |

Communication may be written and/or verbal

Printed Name: _____

Signature: _____ Date: _____

Parent/Guardian/Adult Student

Relationship to Child: _____

Please send information to:
(List School Wanting Info.)

