AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

Date:_____

Student Name: _____ Date of Birth: _____ Grade: _____

Parent(s) Name: _____ Phone:_____

Email:_____

I, as parent or legal guardian of the above named student, give my consent to Wolcott School to release or receive information on my child from a person, school or agency, as indicated below.

☐ Release ☐ Receive

Name:_____ Name:_____

Address:_____ Address:_____

_____ _____

Phone:_____ Phone:_____

The following information is requested to assist in educational planning and coordination of services:

- ☐ Psychological Reports
- ☐ Psychiatric Reports
- ☐ Social Work Reports
- ☐ Medical/Hospital Records
- ☐ General Education Records
- ☐ Special Education Records/Reports
- ☐ Other_____
  _____

Consequences for refusal of consent to disclose (if any):_____

_____

This consent is valid until_____. I understand I have the right to revoke my consent at any time by written notice prior to the expiration of my consent. I understand that if Wolcott School is receiving records from a therapist or agency that has provided for mental health or developmental disabilities services to my child, I have a right to inspect and copy the information to be disclosed.

_____ _____

Parent/Guardian Signature Date Student Signature (if 12 years or older) Date

_____

Witness Date