Iredell-Statesville Schools

Information Release/Exchange

Student _____ Birthdate_____/_____/_____

I hereby give permission for: **To exchange information with:**

School _____ Physician/Therapist_____

Contact_____ Clinic_____

Address_____ Address _____

_____ _____

Phone_____ Phone _____

Fax_____ Fax _____

The reasons for this exchange shall be to develop a better understanding of the student's needs and to develop more effective ways of providing for the needs of the student in school. The information may include:

___ Educational Records

___ Educational Evaluations

___ Educational Checklists (ongoing)

___ Medical Records/Evaluations

___ Social/Developmental History

___ Psychological Evaluation/Treatment Plans

___ Other_____

The consent shall be effective for twelve (12) months from the date signed. I understand that I may revoke this consent at any time except to the extent that action based on this consent has been taken.

_____ _____

Signature Witness

_____ _____/_____/_____

Relation to Student Date

HB 13

Retain a copy of this form in the student's folder