

Permission to Exchange Information

This form authorizes the Frostig Center to DISCLOSE and/or RELEASE information about:

Student's Name: _____ DOB _____

This form must be completed for each Agency/Individual.

AGENCY/INDIVIDUAL: _____

Role in regards to student: _____

Address: _____

Telephone: _____

The purpose of the exchange of information is:

_____ School Admissions review Process

_____ On-going program planning/treatment for an enrolled student

_____ Psycho-educational assessment requested by the parent

_____ Other: _____

The type of information to be exchanged will include:

_____ Educational/language/movement-APE assessments

_____ Medical records/assessment

_____ Grade transcripts

_____ Progress report information/goals and objectives

_____ Psychotherapy reports

_____ Psychological assessments

_____ Other

The period release is valid for:

_____ Ninety (90) days

_____ On-going while receiving services at the Frostig Center

_____ Other

I hereby authorize the Frostig Center to exchange information regarding my child with the above-specified agency/individual.

Parent's Signature

Date

Please return this form to the attention of:

[] Records Librarian

[] Admissions Coordinator

[] Educational Support Services Coordinator

[] Other: _____