Save

WARE COUNTY SCHOOL SYSTEM
Response-to-Intervention/Student Support Team

School Phone:
School Fax: (912)

Date Sent: _____

By: _____

_____ _____
(Name of Student) (Birthdate)

IF AVAILABLE: _____ _____
(ID Number Used) (ID Number Used)

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby request and authorize the following: (identify school, address, phone, & fax)

_____
_____
_____ FAX: (912) _____

to: (check one below)
_____obtain from:
_____release to: _____
_____
_____

the following information from my child's records:

- ☐ *History and Physicals*
- ☐ *Medical diagnosis, medications, and treatment recommendations*
- ☐ *Psychological evaluation*
- ☐ *Educational records, including special education records and psychological evaluations*
- ☐ *Other* _____

for the purpose of planning appropriate educational services.

All information I hereby authorize to be obtained from this agency will be held strictly confidential and cannot be released by the recipient without my written consent.

I understand that this authorization for release of information will expire _____.
(Expiration date)

I understand that unless otherwise limited by state or federal regulation, and except to the extent that action has been taken which was based on my consent, I may withdraw this consent at any time.

_____ _____
(Signature of Parent/Guardian) *(Relation to Student)*

_____ _____ _____
(Witness) *(Title)* *(Date)*