



## AUTHORIZED RELEASE / EXCHANGE OF INFORMATION

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent/ Guardian: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_

City/ State/ Zip: \_\_\_\_\_

I hereby give permission for exchange of verbal, written and/ or electronic information between the Howell Public Schools and:

Name: \_\_\_\_\_

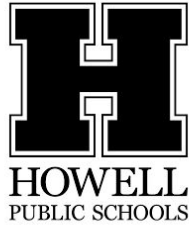
Address: \_\_\_\_\_

City/ State/ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

I understand that my signature authorizes both parties to exchange any and all pertinent data noted below, including psychometric and psychiatric studies, speech, medical and other information designated as "confidential". Data may include information pertaining to the areas indicated below:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> CA-60 Student File      | <input type="checkbox"/> OT/ PT Reports                | <input type="checkbox"/> Psychiatric                   |
| <input type="checkbox"/> Most recent IEP / IFSP  | <input type="checkbox"/> Speech/ Language Reports      | <input type="checkbox"/> Vision/ Hearing Reports       |
| <input type="checkbox"/> Birth Certificate       | <input type="checkbox"/> Social/ Developmental History | <input type="checkbox"/> Academic/ Educational Reports |
| <input type="checkbox"/> Immunizations           | <input type="checkbox"/> Social Work                   | <input type="checkbox"/> Assistive Technology          |
| <input type="checkbox"/> Psychological Reports   | <input type="checkbox"/> Behavior Plan                 | <input type="checkbox"/> Eligibility Reports           |
| <input type="checkbox"/> Substance Abuse Records | <input type="checkbox"/> Court Related Reports         | <input type="checkbox"/> Other                         |
| <input type="checkbox"/> Early Childhood Reports | <input type="checkbox"/> Health/ Medical Records       |  |



The purpose and need for such disclosure is:

- Determination of Special Education Eligibility
- Development of Individualized Education Program (IEP) and/ or Behavioral Intervention Plan
- Coordination of services and continuing care

Please send information to:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/ State/ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Notes:

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I am authorized to release such information as a parent with custody or legally authorized guardian. My authorization is voluntary and shall be effective for one (1) year from the date this form is signed or until I withdraw it in writing.

\_\_\_\_\_  
Parent/ Guardian Signature

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

Distribution Route:  Registry  Parent  CA-60