



_____ (Student's Name) _____ (Date of Birth) _____ (Social Security Number)

_____ (Address) _____ (Grade)

I, _____ give my consent to _____

(Parent) (Discloser)

to exchange information from my records with _____

(Recipient)

I understand that:

- I have no obligation to consent to this release;
 - I have the right to inspect the information to be released;
 - I may revoke this consent at any time by written, date notice to the Supervisor of Special Education/Special Services and that this will prevent the release of any information not already released;
 - I may specify a date, time or condition upon which my consent will expire _____ and that otherwise this consent will automatically expire 12 months from this date, i.e. _____.
- (Date of Expiration)

Even though I consent to release of information, the discloser will not release information if it is considered not in my best interest to do so.

Information is being released for the specific reason of:

- _____ Educational placement
- _____ Therapeutic contact
- _____ Cooperation between Centennial School District and professional/agency
- _____ Other: (Specify) _____

Information disclosed will be limited to:

- | | |
|----------------------------------|---|
| _____ Hospital summaries | _____ Educational records |
| _____ Summary of outpatient care | _____ Psychological report(s) |
| _____ Medical care report(s) | _____ Psychiatric report(s) |
| _____ Other _____ | _____ Description, verification of disability, educational status |

I have read and/or had this form explained to me, understand its contents, and by my signature, consent to the release of the information as described herein.

_____ (Signature of student, if 14 years and older) _____ (Date)

_____ (Signature of parent/guardian [required if student under 18 years of age]) _____ (Date)

SEND ACADEMIC/HEALTH RECORDS TO:

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SEND SPECIAL EDUCATION/
CONFIDENTIAL RECORDS TO:

Supervisor of Special Services
433 Centennial Road
Warminster, PA 18974