EASTFORD ELEMENTARY SCHOOL
PO Box 158; 12 Westford Road
Eastford, CT 06242

AUTHORIZATION FOR RELEASE OF INFORMATION

_____ _____
Student's Name Student's Date of Birth

I hereby authorize Eastford Elementary School to:

_____ send records _____ receive records _____ share information

as checked below.

❒ Academic Records–Cumulative Folder
❒ Health Records
❒ Social Work Records
❒ Psychiatric Evaluations
❒ Psychological Evaluations
❒ Educational Assessments
❒ Individualized Education Program (IEP) (from years _____)
❒ Planning and Placement Team (PPT) Records
❒ Other _____ (please specify)

From: _____
(person or agency name)
Address: _____

_____

To: _____
(person or agency name)
Address: _____

_____

For the purpose of:
❒ Assessment ❒ Transferring Schools ❒ Communication ❒ Other _____

I understand that the medical record to be released may contain information pertaining to psychiatric, drug and/or alcohol abuse diagnoses and treatment.

I understand that I may withdraw this consent at any time prior to the release of the above information. The consent, if not withdrawn, will expire on _____ or 180 days from the date below.

Signature of Parent/Guardian: _____

Relationship to Student: _____ Date: _____

SUBSTANCE ABUSE RECORDS REQUIRE SIGNATURE OF ALL STUDENTS 14 YEARS AND OLDER.