CONSENT FOR MUTUAL EXCHANGE OF INFORMATION

Student: _____ Birthdate: _____
Current School: _____ Grade: _____

For the purpose of providing the most appropriate instruction and assistance in school, I give my permission for mutual exchange of psychoeducational evaluations or medical evaluations between CSC of Eastern Hancock County and the following:
Agency: _____
Address: _____
Contact: _____Date:_____

Purpose for Mutual Exchange: _____
_____
_____

Individual/School Requesting Information:
_____
_____
_____

☐ I give permission for this information to be used in a multidisciplinary team report.

☐ I DO NOT give permission for this information to be used in a multidisciplinary team report.

Parent/Guardian Signature _____

PLEASE RETURN TO: _____

CSC of Eastern Hancock County

10370 E. 250 N. Charlottesville, IN 46117 Tel: (317) 936-5444 Fax: (317) 936-5516