RELEASE OF INFORMATION FORM

For the purpose of providing the most appropriate instruction and assistance in school, I give permission for a mutual exchange of information concerning:

Name of Student: _____ Date of Birth: _____

School Enrolled: _____ Grade Level: _____

Between CSC of Eastern Hancock County and the following:

_____

(Hospital, Clinic, Physician, Institution, Association or School)

_____

(Address of Above)

Name of Contact Person: _____ Phone: _____

_____ Release All Information

_____ Release the Checked Information

- _____ 1. General identifying information (Name, address, birth date, grade level completed, grades, class standing, attendance record).
- _____ 2. Standardized Achievement and Aptitude Test Scores
- _____ 3. Personality and Interest Scores
- _____ 4. Teacher Ratings
- _____ 5. Record of Extra-curricular Activities.
- _____ 6. Individualized Education Programs
- _____ 7. Psychological Reports
- _____ 8. Medical Reports
- _____ 9. Psychiatric Reports
- _____10. Other (Specify)

I understand that: (1) I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization. (2) The information released in response to this authorization may possibly be re-disclosed to other parties. (3) My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

This authorization shall be in force and effect until the Student is no longer enrolled at any school served by CSC of Eastern Hancock County at which time this authorization expires.

Signature of Person Giving Consent: _____

Relationship: _____Phone: _____

Address: _____Zip: _____

Date Signed: _____

Please Return To: CSC of Eastern Hancock County

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