
Confidentiality of Student Records Release Form – Exhibit 2

TO WHOM IT MAY CONCERN:

As a parent (or legal guardian) of _____, I hereby authorize a full study of my child and whatever assistance possible to be given by the members of the Inclusive Education Staff.

I further authorize the release of the appropriate records for this child from: *(here list the names and addresses of the professional people who may have relevant information)*

1. FAMILY DOCTOR:

2. _____

3. _____

4. _____

I wish this information to be further released only to:

1. Assistant Superintendent – Student Services _____

2. _____

I confirm that I have the authority to sign this consent and will inform any other parent or guardian of the contents of this consent and the fact that it has been signed.

(Date)

(Parent's Signature)

(Witness)

(Witness)

Dear Sirs:

We would prefer to discuss this matter with you first. You may contact us by telephoning _____ in order to arrange an appointment.

(Child's School)

(Parent's Signature)