Two-way Release of Information

Student ____

School ________________________________ Grade _____DOB_______________

<u>Healthcare provider(s) – List name, specialty, phone number, fax number, email:</u>

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I, as this student's parent or guardian, give permission for the following records and/or information to be shared both from Perry Township Schools to the student's listed healthcare provider(s), and from the student's healthcare provider(s) to Perry Township Schools. I agree that this release will be in effect for one year from today's date, and will include information communicated by phone, fax, email, and U.S. mail.

Please check all records/information that may be shared:

	Psychological Evaluation		Audiology Evaluations
	Speech, Hearing, Language Evaluation & Therapy		Physical Therapy, Occupational Therapy Evaluation
	Case Conference Report		Ophthalmology Evaluations
	Transcripts & School Records		Counseling Information
	Individual Education Program		Optometric Evaluation
	Individual Health Plan		Probation Information
	Medical Information		Other:

____/____________________

Parent/Guardian Signature   Today's Date

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Printed Name of Parent/Guardian