2018-19
AUTHORIZATION FOR RELEASE OF INFORMATION

Name of Student:_______________________________DOB:________________________

Address: ____

Name of Parent or Guardian: ____

Phone Number(s):____

I hereby give permission for: ____
(outside person and/or agency)

____
(address)

____
(phone number)

to speak with: ____
(LPS representative)

to discuss and/or furnish written information regarding confidential and professional information including medical records and opinions of the above-named student.

This authorization will be in effect for this school year. I understand that I may withdraw this permission at any time upon my written request. I hereby release all parties above from any liability for release of information provided in accordance with this authorization.

Signed: ______________________________________ Date:________________________
(Parent or Guardian)

Signed: ______________________________________ Date:________________________
(Student 18 years of age or older)

Witness:______________________________________ Date:________________________

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