Southgate Community Schools

Department of Special Services
12601 McCann, Southgate MI 48195
Ph. 734-246-4619 Fax 734-284-4476
Kelly Thomas, Director

AUTHORIZATION TO RELEASE INFORMATION

Name Date of Birth

I authorize the Southgate Community School District to disclose/request information in my records to/from:

Name of Individual or Facility

Address of Individual or Facility Telephone

Check Specific Information to be Released/Requested:

- ☐ Psychological Testing
- ☐ Academic Testing
- ☐ Speech and Language Testing
- ☐ Social Work Evaluation
- ☐ IEP, MET, Evaluation Review
- ☐ Intake and Discharge Summary
- ☐ Psychiatric Evaluations
- ☐ Medical Test Reports
- ☐ Other:
- ☐ Other:

The Purpose and Need for Such Disclosure/Request: To develop an Education Plan

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing to the Department of Special Services. Information may have already been released based on this original authorization. We will not release any additional information after we receive your revocation. We will not condition treatment or payment based on this authorization unless otherwise allowed by law.

The requested information will be disclosed as provided by this authorization. This information may be subject to re-disclosure by the recipient and may no longer be protected. This authorization will **expire in 90 days from the date set forth below**, or for the following specified reasons:

Condition: _____ Date: Event: _____

_____ _____
Client/Parent/Guardian Signature Date

_____ _____
Witness Date

A PHOTO COPY OR FACSIMILE OF THIS AUTHORIZATION WILL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL

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