

NEW HANOVER COUNTY SCHOOLS
MUTUAL EXCHANGE OF INFORMATION

Date: _____

Concerning:

Student: _____ DOB: ____/____/____
 Last First Middle

School attending: _____

I, parent or guardian, do hereby authorize the mutual exchange of medical, psychiatric, social work, psychological, educational and developmental history information regarding the above named student between:

New Hanover County Schools

SCHOOL: _____

ADDRESS: _____

ATTENTION: _____

AND

Name or Agency		Mailing Address	

City	State	Zip Code	Phone Number

This authorization will be valid for the period of one year.

The purpose of this information is to ensure that the educational program offered to your child is of the best possible quality. It may be used in making recommendations regarding educational placement, but no decisions will be final without separate consent. I understand that I may revoke this consent at any time except to the extent that action based on this consent has been taken.

This authorization is fully understood and is made voluntarily on my part.

PARENT OR LEGAL GUARDIAN:

Signature: _____

Address: _____

Telephone: _____