STAMFORD PUBLIC SCHOOLS

CONSENT FOR RELEASE/EXCHANGE OF INFORMATION

I, _____, give consent to Stamford Public Schools, to
Name of Parent/Guardian

release information to or obtain information from: _____,
Name of previous school

in regard to (child's name): _____, D.O.B:_____

The above-named agency, school or individual provider's address is: _____

_____
(Previous School Address)

_____
Phone Number Fax Number

Type of information:

- ☐ Medical
- ☐ Psychiatric/Mental Health
- ☐ Academic
- ☐ Behavioral
- ☐ Other (specify):_____

THE PURPOSE FOR REQUESTING THIS INFORMATION IS:

_____

Date of expiration for this consent: one year from date of parent signature.

I understand that I may revoke this consent at any time by notifying Stamford Public Schools in writing. Any information gathered or released prior to the revocation of this consent is valid and cannot be voided. I also understand that, even if I do not revoke this consent, the consent will expire at the end of the year.

Please send/Fax records to:

_____ _____
Signature of Guardian Name of School

_____ _____
Relationship to child School Address

_____ _____
Date City/State/Zip Code

_____ _____
Stamford Public Schools contact Name Phone Number

_____ _____
Stamford Public Schools contact Title and Date Fax Number