FREWSBURG CENTRAL SCHOOL DISTRICT
AUTHORIZATION FOR RELEASE OF RECORDS

MUTUAL RELEASE OF INFORMATION

Student Name: ____________________________________ Date of Birth: __________________

Address: ____

____

I hereby give consent to the Frewsburg Central School District to:

OBTAIN and RELEASE

Pertinent information via verbal or written regarding my child's mental health records, IEP, psychological, medical, social and/or educational history and discipline records to and from:

Name/Attention: ____

Address: ____

____

Phone: ____________________________________ Fax: _________________________________

****

Signed: ____ Date: _________________________

Address: ____

____

Phone: ____

Relationship to student: _____________________________