PERMISSION FOR RELEASE OF INFORMATION

I do hereby authorize the Sequatchie County School System to:

_____Release information to: _____Obtain information from:

Physician/Institution Name: _____

Address: _____

City, State, Zip Code: _____

Phone Number: _____

Student's Name: _____ Date of Birth:_____

In order to develop an Individualized Health Plan and/or an Individual Education Plan, as well as to facilitate continuity of treatment for this student, it is important to obtain the following information:

_____Physical Examination

_____Psychosocial Evaluation

_____Psychiatric Evaluation

_____Psychological Evaluation

_____Neurological Evaluation

_____Discharge Summary

_____Laboratory Tests

_____Treatment Plan

_____Verbal Communication

_____Physician's Orders for Procedures at School

Please include diagnosis, date seen by doctor(s), treatment and progress, prognosis, and recommendations for handling this need at school.

_____This information is confidential and shall only be viewed by the individuals listed below:

Name:_____ Position:_____

Name:_____ Position:_____

Name:_____ Position:_____

_____This information is confidential and may be viewed by all personnel directly involved in the welfare of my child.

_____ _____

Parent /Guardian Signature Date