Conestoga Valley School District
2110 Horseshoe Road
Lancaster, PA 16701
(717) 397-2421
FAX (717) 397-0442

PARENT/GUARDIAN CONSENT FOR RELEASE OF INFORMATION

In regard to: Student Name: ______________________________ DOB: __________________

By placing my **INITIALS** on the line(s) in front of the categories listed below, I give Conestoga Valley School District consent to release information regarding the above student either verbally or in writing in the following categories to the agency/person/institution identified below.

_______ Teacher Reports including observations, anecdotal notes, summaries, rating scale completion
_______ Counselor Reports including observations, summaries, rating scale completion
_______ Special Education Records including Evaluation Reports, Individualized Education Plan's, 504 plans
_______ IU Instructional Personnel Reports including OT/PT reports
_______ Report Cards/Transcripts
_______ Attendance Reports
_______ Discipline Records
_______ Other:____

Agency, person, or institution authorized to receive information regarding the above student:

Identifying Name:____

Address: ____

Phone/Fax:____

The information is to be released for the purpose of ____
____
and with the understanding that appropriate confidentiality will be maintained. Photostatic copies of this authorization shall be considered valid.

____
Parent, Guardian, Student or Surrogate Parent's Signature

_______________________________ _______________________________
Address Phone

_______________________________ _______________________________
City, State, and Zip Code Date (this permission expires 1 year from this date)

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PARENT/GUARDIAN CONSENT TO RECEIVE INFORMATION

In regard to: Student Name: ______________________________ DOB: __________________

By placing my **INITIALS** on the line(s) in front of the categories listed below, I hereby consent to the below named agency/person/institution disclosing information regarding the above student to Conestoga Valley School District either verbally and/or in writing in the following categories.

_______ Psychological/Neuropsychological Evaluation Reports including DSM diagnoses
_______ Psychiatric Evaluation Reports including DSM diagnoses and prescribed medications
_______ Behavioral Health Reports including clinical records, treatment plan, discharge summary
_______ Counselor/Therapist Communication including observations, therapy goals, family history
_______ Medical Records including family history, diagnoses, medications, medical reports, clinical reports
_______ Other: ____

Agency, person, or institution authorized to release this information:

Name: ____

Address: ____

Phone/Fax: ____

The information is to be received for the purpose of ______________________________________
____
and with the understanding that appropriate confidentiality will be maintained. Photostatic copies of this authorization shall be considered valid.

Please forward all requested records to the attention of: ______________________________
at the address listed on the top of this page.

____
Parent, Guardian, Student or Surrogate Parent's Signature

______________________________ ______________________________
Address Phone

______________________________ ______________________________
City, State, and Zip Code Date (this permission expires 1 year from this date)

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