

Worthington City School Release/Exchange of Information Authorization

Thereby authorize the Worthington Schools to release and obtain p	pertinent information concerning:
Student's Full Name:	
Student Date of Birth:	
with (name and contact information of individual and/or agency): _	
This information may include medical, psychological, psychiatri (including, but not limited to IEP's and ETR's) which might be he follow-up of any therapeutic measures. It is understood that this any other person without parental consent.	elpful in educational planning and ir
In addition to the release of medical, psychological and/or ed communication between appropriate Worthington Schools individual(s)/ agency.	
I understand this information is confidential and will be released actional Rights Privacy Act (FERPA). I understand that I may submitting written notice of the withdrawal of consent to this expressly revoked earlier) is valid for one calendar year from which	revoke this consent at any time by school district. This consent (unless
Signature of Parent/ Guardian/ Student if 18 or older	Date
Address:	_
Relationship to Student:	_
Signature of Witness	