

# Consent for Release of Records/Information

STUDENT'S NAME:	DOB:	
Agency/Individual:		
Address:		

<input type="checkbox"/>	<b>1. Release of Records/Information to My Child's School at Nassau BOCES</b>		
	<i>Please forward copies of all academic, psychological, psychiatric, medical records from _____ to the school listed below:</i>		
	<p><b>Nassau BOCES</b>  <b>Center for Community Adjustment</b>                  2850 North Jerusalem Road                  Wantagh, NY 11793</p> <p><b>(516) 396-2900</b></p>		
	<p><i>I authorize the agency/individual indicated above to release academic, psychological, psychiatric, medical and all other evaluations and records to the school district. I understand that all records will be kept confidential and that access will be limited to school personnel who work with my child. I understand that my consent is voluntary and can be withdrawn at any time.</i></p>		
	<table style="width: 100%; border: none;"> <tr> <td style="width: 70%; border: none;"><i>Signature of Parent / Guardian</i></td> <td style="width: 30%; border: none;"><i>Date</i></td> </tr> </table>	<i>Signature of Parent / Guardian</i>	<i>Date</i>
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<input type="checkbox"/>	<b>2. Consent for Verbal Communication</b> <i>(between School Personnel and an Individual/Agency)</i>		
	<p><i>I consent to having school personnel who work with my child (principal, psychologist, social worker, or special education teachers, related service providers and/or CSE/CPSE Chairperson) speak with the individual/agency indicated above. I understand that my consent is voluntary and I may withdraw consent for future communications at any time.</i></p>		
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