ACSD
Addison Central School District
49 Charles Ave
Middlebury, VT 05753
802.382.1274 (Phone)
802.388.0024 (Fax)

PERMISSION TO OBTAIN OR RELEASE INFORMATION

Student Name: _____ DOB: _____

I give permission for _____ to obtain and release information on
(school/district)
my child,_____, from/to the following school, agency or persons:

1. Name(s) of School, Medical Provider, Agency or Individual:

2. Specifications of records/information to be obtained/released:

3. The purpose(s) of the disclosure is/are:

   To collect data/information about _____and coordinate services for

Signature: _____

Printed Name: _____

Date: _____ Relationship to Child: _____

To be completed by the school registrar

The student's files include a(n):

☐ IEP Plan ☐ 504 Plan ☐ EST Plan ☐ Health Plan

☐ Other _____ ☐ No additional plan

** All IEPs should be forwarded to the Specialized Services Program Coordinator (Erin Robinson) and the school administrator(s) as soon as it is received (electronic copy preferred).