



NORTH COASTAL CONSORTIUM
FOR SPECIAL EDUCATION

Authorization For Exchange Of Information

Page ___ of ___

District _____

Date _____

Student _____ Last _____ First _____ DOB _____

Address _____

City _____ State _____ Zip _____

Phone _____

Home _____ Work _____ Case Manager _____

I hereby authorize the exchange of records between the following:

Agency: _____

School District: _____

Attn.: _____

Please send records to the above stated school district.

1. Requested records will be used for the following purpose(s):

2. This authorization shall remain for one year from the date of signature unless revoked in writing by the pupil or the pupil's parent, guardian or conservator.

I hereby consent to the release of :

- Audiological reports IFSP Medical reports PT/OT evaluation, progress reports
- Educational reports IPP Psychological/psychiatric reports Other _____

Person giving consent _____ Date _____

Indicate relationship to pupil: Guardian Parent Self Surrogate