Buncombe County Schools
PARENT/GUARDIAN CONSENT FOR RELEASE OF INFORMATION

Student:_____DOB:_____

School:_____Teacher:_____Grade:_____

I hereby authorize Buncombe County Schools and:

(Agency or
Individual):_____

(Address if known):_____

(Phone Number if known):_____(Fax Number if known):_____

to exchange information about the above-named student, for the purpose of contributing to individual educational planning for him/her. Specific information to be released is checked below.

_____Educational _____Counseling _____Medical _____Speech/Language

_____Occupational Therapy _____Physical Therapy _____Psychological

_____Other (specify) _____
_____
_____

I understand that the information to be exchanged will not be released to other agencies without my prior written consent. I also understand that I may revoke this authorization at any time.

_____ _____
(Parent/Guardian Signature) (Relationship to Student)

_____ _____
(Witness to Signature) (Date)

_____
(Expiration Date)