



1819 S. Wagner Rd.
Ann Arbor, MI 48106
734.994.8100

AUTHORIZED RELEASE/EXCHANGE OF INFORMATION

Name: _____
Parent/Guardian: _____
Address: _____
City/State/Zip: _____

Date of Birth: _____
Home Phone: _____

I hereby give permission for exchange of verbal, written, and/or electronic information between _____ and:

Name: _____
Address: _____
City/State/Zip: _____
Phone: _____ Fax: _____

I understand that my signature authorizes both parties to exchange any and all pertinent data noted below, including psychometric and psychiatric studies, speech, medical, and other information designated as “confidential.” Data may include information pertaining to the areas indicated below:

Most Recent	History		Most Recent	History		Most Recent	History	
<input type="checkbox"/>	<input type="checkbox"/>	CA-60 Student File	<input type="checkbox"/>	<input type="checkbox"/>	OT/PT Reports	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric
<input type="checkbox"/>	<input type="checkbox"/>	IEP/IFSP	<input type="checkbox"/>	<input type="checkbox"/>	Speech/Language Reports	<input type="checkbox"/>	<input type="checkbox"/>	Vision/Hearing Reports
<input type="checkbox"/>	<input type="checkbox"/>	Birth Certificate	<input type="checkbox"/>	<input type="checkbox"/>	Social/Developmental History	<input type="checkbox"/>	<input type="checkbox"/>	Academic/Educational Reports
<input type="checkbox"/>	<input type="checkbox"/>	Immunizations	<input type="checkbox"/>	<input type="checkbox"/>	Social Work	<input type="checkbox"/>	<input type="checkbox"/>	Assistive Technology
<input type="checkbox"/>	<input type="checkbox"/>	Psychological Reports	<input type="checkbox"/>	<input type="checkbox"/>	Behavior Plan	<input type="checkbox"/>	<input type="checkbox"/>	Eligibility Reports
<input type="checkbox"/>	<input type="checkbox"/>	Substance Abuse Records	<input type="checkbox"/>	<input type="checkbox"/>	Court Related Reports	<input type="checkbox"/>	<input type="checkbox"/>	Other
<input type="checkbox"/>	<input type="checkbox"/>	Early Childhood Reports	<input type="checkbox"/>	<input type="checkbox"/>	Health/Medical Records	<input type="checkbox"/>	<input type="checkbox"/>	

The purpose and need for such disclosure is: Educational Planning Other

Please send information to:

I am authorized to release such information as a parent with custody or legally authorized guardian. My authorization is voluntary and shall be effective for one (1) year from the date of this form. I can revoke this authorization at any time. Revocations must be made in writing and sent to the address listed at the top of this form. Revocations will not apply to information that already has been released. I also understand that re-disclosure of this information to a party other than the one designated above is forbidden without additional written authorization on my part.

Parent/Guardian Signature

Witness

Date

Date