



AUTHORIZATION TO RELEASE RECORDS

Student Name: _____

Date of Birth: _____

To: _____
(Name of school, doctor, therapist or services provider)

(Address)

_____ (Phone) _____ (Fax)

As parent/guardian of above named minor child, I authorize the release and exchange of confidential educational materials, medical records, diagnoses, psychological evaluations, special education records and other information between _____ and St. John the Baptist School to be used to support my student's educational needs. I also give permission for verbal exchange of information.

I hereby approve the release of information as indicated above. A copy of this authorization shall be deemed as original. I may revoke this authorization in writing at any time. Such revocation may not be retroactive.

Printed Name of Parent or Guardian

Relationship

Signature of Parent/Guardian

Date

Please send information to:

Staff Member: _____
Street Address: 10956 SE 25th Ave
City, State, Zip: Milwaukie, OR 97222
Tel: 503-654-0200 Fax: 503-654-8419