

Authorization for Consent for Release of Information

Name: _____ Date of Birth: _____

I hereby authorize Center for Behavior Intervention to disclose general information, records, and/or special education records to:

Name: _____

Address: _____

Phone: _____

Email: _____

_____ **Initial here if authorization is given for the parties listed above to mutually exchange the information below.**

_____ All General Education Records

(Including but not limited to: Grade Reports, Attendance Reports, Health/Immunization, Achievement Test Scores, Cumulative Record)

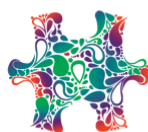
_____ All Special Education Records

(Including but not limited to: Eligibility, IEP's, Conference Reports/Case Study, Speech/Language Report, Health History (excluding mental), Social History (nonmedical) and/or Progress Reports)

_____ Other (specify) _____

This authorization expires on _____. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I understand that my revocation of this authorization will not be effective for actions taken by the Center for Behavior Intervention or health care provider in reliance upon my authorization and prior to notice of my revocation. I understand that failing to authorize disclosure of records may adversely impact the educational programming and/or medical treatment for my child. I also understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain health care. I also understand that I have the right to inspect and copy informational records to challenge their contents.

Parent/Guardian: _____ Date: _____



The Centers for
Behavior Intervention

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