



Seven Sorrows

of the Blessed Virgin Mary School
360 E. Water Street; Middletown, PA

PERMISSION TO EXCHANGE INFORMATION Seven Sorrows School to Receive/Release Information

Name: _____ Grade: _____ DOB: _____
 School: _____

By placing my initials on the line(s) in front of the categories listed below, I give Seven Sorrows BVM School consent to release and receive information in that category.

____ Psychological Reports

____ Psychiatric Reports

____ School Records (Cumulative File, IEP, 504 Plan, ER, NORA)

____ Medical History, Medical Reports, Clinical Reports, Laboratory Reports

____ Pre-School Reports

____ Counselor or Teacher Reports (Observations Anecdotal Records)

____ Neuro-Developmental Clinic Record/Reports

____ Physicians Reports

____ Other: (Specify: Verbal Communication for continuity of care) _____

Other Agencies, Persons or Institutions Authorized to Receive/Release Information:

Identifying Name	Phone	Address
_____	_____	_____
Identifying Name	Phone	Address
_____	_____	_____

This information is to be exchanged with the understanding that appropriate confidentiality will be maintained. Photo static copies of this authorization shall be considered valid. The permission granted shall be for one year from: _____ to _____.

Parent/Guardian Name: _____

Address: _____ City: _____ State/Zip: _____

Phone: _____ Email: _____

Signature _____ Date _____