Hamilton-Boone-Madison Special Services Cooperative
Hamilton-Boone-Madison Education Center
1775 Field Dr., Noblesville, IN 46060
Phone: 317-773-2134
Fax: 317-773-2136

CONSENT FOR RELEASE OF INFORMATION

Student's Name: DOB:

District: Bldg: Grade:

Parent(s)/Guardian Name: Phone:

Address: City/St: Zip:

The (school or coop) may:

☐ Send Information to: ☐ Receive Information from:

Agency/Person:

Address:

City/State: Zip: Phone:

Please send the following information records to assist with the above student's educational programming:

☐ Educational Records
☐ Psychological/Psychiatric
☐ Social work
☐ Speech/Language
☐ Other
☐ Audiological
☐ Medical/Health
☐ Physical Therapy
☐ Occupational Therapy

This consent for release or exchange of information is authorized for twelve months. I understand that I may revoke my consent at any time by notifying _____ (District/School) **in writing that I am revoking consent. I also understand that my revocation does not apply to action taken before I revoked my consent.**

_____ _____

Signature of Parent/Guardian or student if age 18 Witness

Date: _____ Date: _____

Please return to:

School
Address
City/ST/Zip
Phone
Fax
Attention Of: