

**CONSENT FOR RELEASE OF INFORMATION
FOR INTERDISTRICT REFERRAL**

Concerning: _____
Name Birthdate

I, the undersigned, hereby consent to, request, and authorize the agencies listed below to release any or all medical, social, psychological, and educational information regarding the above named person to the _____
 _____ (*Name of School District/Agency*) for inclusion in their records which are to be used for planning an effective school program for this person.

I also consent to, request, and authorize said _____ (*Name of School District/Agency*) to release the said information upon request to agencies or professionals listed below.

A photocopy of this is as valid as the original.

The records of my child may be obtained from:

MEDICAL

 Name Address City State

 Name Address City State

 Name Address City State

EDUCATIONAL

 Name Address City State

AGENCY

 Name Address City State

Signature of Parent or Guardian: _____

Relationship to Above-Named Person: _____
Parent/Guardian

Date: _____

WITNESS: _____ (*Signature*)
 _____ (*Address*)