AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

NAME: ______________________________

BIRTHDATE: ______________________________

I request that you release all information you have of an academic, social, medical and psychological nature on the above-named child. I request that the information be kept confidential and be used for professional reasons only.

NOTE: ***The authorizing party is entitled to an explanation of how the information will be used, how it will be maintained, how long it will be retained, and to whom it will be available.***

SIGNED: ____________________ **DATE:** __________

RELATIONSHIP: ______________________________

REQUESTED BY: ______________________________

OFFICIAL TITLE: ______________________________

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Information to be released
TO [ ]: FROM [ ]:

Special Services Unit
702 Elm St
Madison, IN 47250-1129

Information to be released
TO [ ]: FROM [ ]:

____
Name

____
School or Organization

____
Address

____
City **State** **Zip**

After completing this form please return it to the individual listed below for processing:

ATTENTION: ______________________________

Special Services Unit
702 Elm St.
Madison, IN 47250-1129
PHONE: (812) 265-3448
FAX: (812) 265-3459

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