Camden School District, Division of Special Services
201 North Front Street Camden, New Jersey 08102
Telephone (856) 966-2000

RELEASE OF INFORMATION

STUDENT NAME: ____

DOB: ____

Date: ____

School/Agency: ____

Address or Phone: ____

I am authorizing the release of information pertaining to my child to the above-named school or agency. Information released may include:

- ☐ All Child Study Team evaluations (including Speech, OT/PT, Functional Behavior Assessments, etc.)
- ☐ Current IEP
- ☐ Classification conference report
- ☐ Medical and immunization information
- ☐ Information regarding my child’s current levels of functioning and/or progress.

Information may be released:

- ☐ Verbally
- ☐ In writing

The parent/guardian's signature below will authorize the release of information between Camden City Schools CST and the above-named school or agency.

Thank you for your prompt attention to this request.

Name of Parent/Guardian (Printed): ____

Parent/Guardian Signature: ______________________________ **Date:** ____________________

CST Name (printed): ______________________________ **Phone:** ____________________

CST Signature: ____

CST Email: ____