

AUTHORIZATION FOR RELEASE OF INFORMATION

OPTIONAL FORM: Used by School District Counselling & Education Support Services

Date: _____ (consent is valid for one year from signing date)

Re: Student Legal Name _____ Birth Date _____

Personal Health Number (if applicable) _____

Consent

- ☐ Permission is granted for the release and exchange of information regarding the above named student for the purposes of developing a better understanding of the student, and to assist in the developing of appropriate academic, social and behavioural programming.
- ☐ I understand and give permission for these people to attend planning meetings with me.
- ☐ I understand that I may add or remove any names from this list at any time, or specify any limitation to this consent.
- ☐ I hereby release persons/agencies, from any and all claims whatsoever which may arise as a result of the release of the above information.

Parent /Guardian, person authorized to sign:

Print name

Signature

Person/Agency contacts: (fill-in as needed)

Person _____ Phone _____ Fax _____

Agency _____ Address _____

Person _____ Phone _____ Fax _____

Agency _____ Address _____

Person _____ Phone _____ Fax _____

Agency _____ Address _____

Person _____ Phone _____ Fax _____

Agency _____ Address _____

Person _____ Phone _____ Fax _____

Agency _____ Address _____

School Personnel requesting information/consultation:

Name: _____ Position: _____

Address/Postal Code: _____

Telephone: _____ Fax: _____

LEADERSHIP IN LEARNING

Surrey School District 36 - Student Support - Education Services Department 14033 92nd Avenue, Surrey, B.C. V3V 0B7

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