



**CONSENT FOR RELEASE OF INFORMATION**

I (Parent/Guardian), \_\_\_\_\_, give permission to Wooster City Schools to consult with the individuals or agencies listed below and to obtain from or release to them any information concerning:

(Student Name) \_\_\_\_\_ Date of birth: \_\_\_\_\_

Information requested:

- \_\_\_\_\_ Psychological evaluations, academic progress, standardized test results
- \_\_\_\_\_ Social history and counseling records
- \_\_\_\_\_ Health and medical information
- \_\_\_\_\_ Other

Individuals / Agencies included in Release:

1. \_\_\_\_\_ Address \_\_\_\_\_
2. \_\_\_\_\_ Address \_\_\_\_\_
3. \_\_\_\_\_ Address \_\_\_\_\_

Reasons for release of information:

\_\_\_\_\_

Wooster City Schools Personnel sending / receiving information:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
(Parent/Guardian Signature)

\_\_\_\_\_  
(Address)

Date signed: \_\_\_\_\_

This permission may be revoked at any time upon request of the parent/guardian and is in effect during the \_\_\_\_\_ school year.