Hope Technology School:
Consent for Release of Information

I hereby give my permission to release the following records:

❒ Audiological ❒ Psychological ❒ Educational

❒ Speech/language Therapy ❒ Medical ❒ Occupational Therapy

❒ Physical Therapy ❒ Other: _____

❒ Other: _____

Please provide names and addresses of professionals on opposite page.

Specific Information Requested:

❒ Patient/Client Records ❒ Diagnosis/ Evaluation Reports ❒ Dates of service

❒ Other: _____

To:

Hope Technology School and Staff

2525 E. Bayshore Road

Palo Alto, CA 94303

Phone: (650)565-8391

Fax: (650)565-8624

Re:

Student Name
Date of Birth
Address
City, State, Zip

Signature Parent/Legal Guardian	Date

Release of Information, Continued – Please fill in information for agencies or persons that you would like to give us permission to exchange information with.

Name
Agency
Address
City, State, Zip
Phone

Name
Agency
Address
City, State, Zip
Phone

Name
Agency
Address
City, State, Zip
Phone

Name
Agency
Address
City, State, Zip
Phone

Name
Agency
Address
City, State, Zip
Phone

Name
Agency
Address
City, State, Zip
Phone