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

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

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