Consent for Release of Information

Hope Technology School

I, _____ (Parent/Guardian name), hereby give my permission to release the following records to the Hope Technology School and Staff:

- ☐ Audiological
- ☐ Educational
- ☐ Psychological
- ☐ Occupational Therapy
- ☐ Speech/language Therapy
- ☐ Physical Therapy
- ☐ Medical
- ☐ Other: _____
- ☐ Other: _____

Please provide names and addresses of professionals on the opposite page.

Specific Information Requested:

- ☐ Patient/Client Records
- ☐ Diagnosis/Evaluation Reports
- ☐ Dates of service
- ☐ Other: _____

_____

Parent/Guardian Signature

_____

Date

Agency Contact Information

Please fill in information for agencies or persons that you would like to give us permission to exchange information with.

Agency Name: _____

Contact Name: _____

Street Address: _____

City, State, Zip: _____

Phone: _____

Agency Name: _____

Contact Name: _____

Street Address: _____

City, State, Zip: _____

Phone: _____

Agency Name: _____

Contact Name: _____

Street Address: _____

City, State, Zip: _____

Phone: _____

Agency Name: _____

Contact Name: _____

Street Address: _____

City, State, Zip: _____

Phone: _____

Agency Name: _____

Contact Name: _____

Street Address: _____

City, State, Zip: _____

Phone: _____