OAK RIDGE SCHOOLS
Department of Pupil Services/Special Education
P.O. Box 6588
Oak Ridge, TN 37831-6588
(865) 425-9009 Office
(865) 425-9061 Fax

RELEASE OF CONFIDENTIAL INFORMATION

Full Name of Child ______________________________ Birthdate ______________

I do hereby authorize the Oak Ridge Schools to release to and/or receive from:

Agency ____________________________________ Telephone ______________

Address ____

the following specific information concerning my ____________________________.
(Relationship)

_______ Medical history/treatment reports
_______ Social history and related material
_______ Counseling treatment reports and progress in program including attendance and participation.
_______ Evaluation reports including psychiatric, psychological, academic achievement, etc.
_______ Other, specify: ____

I understand that this information will be used for evaluation and planning to meet his/her educational needs.

I understand no information may be disclosed by either agency to any other individual or agencies unless by my written consent. This consent for release of information is given freely, voluntarily and without coercion.

Parent/Guardian Signature ______________________
Address ______________________________
____
Telephone ______________________________
Date ______________________________

Principal ______________________
Counselor ______________________
Psychologist ______________________
Other ______________________

ATTENTION: THIS RELEASE EXPIRES ONE YEAR FROM THE DATE SIGNED.

Revised January 2007