LAKELAND SCHOOL DISTRICT
1355 Lakeland Drive
Scott Township, PA 18433
Phone: 570-254-9485 Fax: 570-254-7085

CONSENT FOR THE RELEASE/OBTAIN OF INFORMATION

Student Name: ________________________ Grade: ______ Date of Birth: _______________

Parent/Guardian's Name: ____

Address: _______________________________ Home Telephone: _____________________

_______________________________ Other Telephone: _____________________

I, ________________________________, hereby authorize Lakeland School District, to obtain from / release to:

____
Name/Facility

____
Address

____
Phone Number **Fax Number** **Email address**

Information obtained will be for the purpose of assessment and evaluation.

The information should include the following data (check all that apply):

Psychiatric Evaluations	School/Academic Records
Psychological Evaluations	School/Academic Reports
Physical Examinations	Drug/Alcohol Information
Neurological Studies	Treatment Plans
Neurological Testing/Consultations	Intake Summaries
Psycho-Social Histories	Case Management Notes
Medical Histories	Verbal Exchange of Information
Psychiatric Histories	Other: _____________________________

This release covers the time period: ______________ to ______________ and is effective for up to one year.
Date Date

I have been informed that according to confidentiality regulations, my signature is necessary and that this release is limited to the person/organization, the purpose, and the time indicated on this form. I also understand I may withdraw my permission at any given time, although I must do so in writing.

____
STUDENT SIGNATURE (Required if over the age of 14) DATE

____
PARENT/GUARDIAN SIGNATURE RELATIONSHIP DATE

____
WITNESS RELATIONSHIP DATE

If unable to provide written signature, provide for two witnesses acknowledging verbal consent.

______________________________ ______________________________
WITNESS DATE WITNESS DATE

9/2013