Brightside Educational Evaluations

Authorization for Release of Confidential Information

Student Name: _____ Date of Birth: _____

Parent/ Guardian Name: _____

Address: _____

I authorize the exchange of information described below between Brightside Educational Evaluations and the following agency(s) and/or individual(s):

☐ Educational Agency
School/District: _____
School Address: _____
School Phone: _____
Contact Person: _____

☐ Healthcare Provider(s) / Other
Name : _____
Address: _____
Phone : _____
Contact Person: _____

The authorization applies to the following information:

- Medical Records
- IEP's
- Psychological Reports
- Student Study Team Notes
- Grades/Progress Reports
- Mental Health Records
- 504's
- Assessments
- Attendance Records
- Behavior Records

Signature: _____ **Date:** _____

Relationship to Student: ☐ Parent ☐ Legal Guardian

Expiration: This authorization expires 1 year from this date

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