Collaborative Educational Advocacy and Consulting

Authorization for Release of Information

I, _____, give permission to Collaborative Educational Consulting
(client/parent/guardian)

and Advocacy to communicate with _____, relating to
(outside agency)

_____, This includes educational record(s), special education
(student/minor)

record(s), assessment and testing record(s), health and medical record(s), attendance and

disciplinary records(s) and communication with Collaborative Education Consulting and Advocacy.

DURATION: This authorization shall be effective immediately and shall remain in effect until

_____ or for one year from the date of signature if no date entered.
(date)

YOUR RIGHTS: I understand that the following rights with respect to Authorization: I have the right to receive a copy of the authorization. I may revoke the authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the Outside Agency listed above and to Collaborative Educational Advocacy and Consulting. My revocation will be effective upon receipt by Collaborative Educational Advocacy and Consulting.

APPROVAL: _____
(Printed Name)

Signature: _____

Relationship to Student/Minor: _____

Date: _____