FAUQUIER COUNTY PUBLIC SCHOOLS
Authorization to Release Confidential Information

NAME:_____
(Name of Client)

ADDRESS:_____
(Street Number, Post Office Box, Route Number)

_____
(City) (State) (Zip Code)

I authorize the following individuals/organizations:

_____
(Individual, Medical Doctor, Hospital, Clinic, Attorney, Counselor, School, Etc.)

_____
(Street Number, Post Office Box, Route Number) (City) (State) (Zip Code)

to release the following specific confidential information:

Yes [ ] No [ ] Educational Information

Yes [ ] No [ ] Developmental Information.

Yes [ ] No [ ] Medical Information.

Yes [ ] No [ ] Special Education-Related Information

Yes [ ] No [ ] Psychological Reports

Yes [ ] No [ ] Social History—Related Information

Yes [ ] No [ ] Other. Indicate specific information.

_____

to _____

_____

THIS AUTHORIZATION IS EFFECTIVE UNTIL I REVOKE IT IN WRITING.

This form (___) was read by me (___) was read to me and I understand its meaning. All the blanks were filled in before the form was signed by me.

_____Date_____
(Signature)

_____
(Print/Type Name of Person Authorized to Consent to Release of Information)

_____
(Signature of Authorized Person) (Relationship to Client)

_____
(Address) (Telephone)