

**BRITTEN SCHOOL
AUGUST 2016-AUGUST 2017**

AUTHORIZATION FOR RELEASE OF INFORMATION

Student's Name _____ **Date of Birth** ____/____/____

The undersigned hereby authorizes and requests Britten School to exchange information with:

Individual **Organization**

Street Address **Telephone**

City, State, Zip Code **Fax**

The information released includes only the following information:

_____ Legal	_____ Vocational
_____ Health/Medical	_____ Educational
_____ Psychiatric/Psychological	_____ Other (Please Specify)

The purpose of this release of information is for the coordination of educational and support services.

This authorization is valid for the school year 2016-2017, unless otherwise specified.

I fully understand the following conditions:

1. The record and/or information that is to be released herein is privileged and confidential and may be released only by proper authorization, except as required by law.
2. I have the right to revoke this authorization at any time by submitting a written revocation to Britten School.
3. A copy of this authorization is as valid as the original.

Parent/Guardian Signature **Date**

Signature of Student (if over 12 years of age) **Date**

Witness **Date**