Exceptional Programs for Exceptional Students

Ivymount Autism Program
Student Information Release Form
2016-2017 School Year

I, ____, hereby authorize:

Name: ____

Agency: ____

Address: ____

____

Telephone: ____

to exchange with staff of the Ivymount School, the following information

concerning:__________________________________
(Name of Child)

____ Psychological Evaluation
____ Psychiatric Evaluation
____ Neuropsychological Evaluation
____ Speech/Language Evaluation
____ Occupational Therapy Evaluation
____ Educational Assessment
____ Psychological Assessment
____ Treatment Summary
____ Discharge Summary
____ IEP
____ Medication Evaluation
____ Physical Examination
____ Other: _________________________
____ Other: _________________________

I authorize the exchange of this information via:

- ❑ Direct contact (e.g., in person, phone conversation)
- ❑ Electronic mail
- ❑ Written documentation

This information will be used for the purpose of planning and implementing programs. I understand that I may withdraw my consent at any time.

____________________________________ ______
Signature of Parent or Guardian Date

11614 Seven Locks Road, Rockville, Maryland 20854 Tel 301-469-0223 Fax 301-469-0778 www.ivymount.org