THE IVYMOUNT SCHOOL
11614 Seven Locks Road
Rockville, MD 20854
(301) 469-0223
FAX: (301) 469-0778

Please check all that apply:

___ Authorization to <u>Release</u> Information to…
___ Authorization to <u>Obtain</u> Information from…
___ Authorization to <u>Exchange</u> Information with…
<u>(obtain and release)</u>

I hereby authorize the release of the following records for my child, _____,

_____from (___) agency or clinician named below to Ivymount School
Date of Birth

and / or from (___) Ivymount School to the named agency.

_____ Educational Assessment
_____ Occupational/Physical Therapy Report
_____ Speech/Language Report
_____ Medical Record/Immunization Record
_____ Psychological or Neuro-psychological Evaluation
_____ Educational Consultation
_____ Psychiatric Evaluation
_____ Counseling Treatment Summary
_____ Individual Educational Plan
_____ Discharge Summary
_____ Verbal exchange of information between Ivymount and named agency/clinician
_____ Other (please specify) _____

_____
Name of Agency and/or Clinician (Please Print)

_____
Complete Mailing Address of Agency (Street, City, State, Zip)

_____
Contact Person **Phone #** **Fax#**

_____
Email address

This information will be used for the purpose of planning and implementing programs. I understand that this authorization is valid for a period of <u>one calendar year from the date of signature below</u>. I further understand that I may cancel or revoke this authorization at any time in writing.

_____ _____ _____
Printed Name of Parent/Guardian **Signature of Parent/Guardian** **Date of Signature**