**Records Release and Parental Consent Template**

Date:

**Provider**

**Practice**

**Address**

**Telephone**

**Fax**

To: \_\_\_\_School (child attends)

To: Parents of (name of child, birthdate)

As part of (child’s name, birthdate), routine health care, we would like to review school records including:

 \_\_\_ Standardized academic achievement test scores

 \_\_\_ Any special education or Title 1 test scores

 \_\_\_ Attendance Records

 \_\_\_\_Discipline records (if applicable)

 \_\_\_\_ Contact information for this patients’ teacher

We ask that *(check one of the following)*:

\_\_\_\_Parents request these records from the school and deliver to our office on or before your child’s next appointment on (date): \_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_schools release the above information to this office before (date): \_\_\_\_\_\_\_\_

\_\_\_you provide teacher name and contact information:

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_teacher name

 teachers’ preferred contact method:

 \_\_telephone

 telephone number \_\_\_\_\_\_\_\_\_\_

 best time to call: \_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_fax, fax number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_email, email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If school records are not available, please give me a call at: \_\_\_\_\_\_\_\_\_\_

Our office also requests permission to communicate with school personnel about this child’s difficulties and progress and to share our findings. You can contact us by *(check all that apply and complete contact information):*

\_\_telephone

 telephone number \_\_\_\_\_\_\_\_\_\_

 best time to call: \_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_fax, fax number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_email, email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent consent and signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please return this form to me, when completed, at the above address

Sincerely,

\_\_\_\_\_\_\_\_\_\_

Provider

Clinic

Cc: *Parents, their address, phone, email*