



THE SYCAMORE  
SCHOOL  
Learning Rediscovered

**AUTHORIZATION FOR EXCHANGE OF INFORMATION**

I authorize the following organizations, The Sycamore School, and \_\_\_\_\_ to release/exchange information and share communication in verbal, written, and/or electronic form regarding:

\_\_\_\_\_  
(Student Name) (Date of Birth)

This information is to be used for educational evaluation and program planning.

Information for release includes the following: (Please Check)

- \_\_\_\_\_ Grades/Report Card
- \_\_\_\_\_ Standardized Test Results
- \_\_\_\_\_ Health/Immunization Records
- \_\_\_\_\_ Attendance Records
- \_\_\_\_\_ Transcripts/Credit Data
- \_\_\_\_\_ Discipline Records
- \_\_\_\_\_ Psychological/Psychoeducational/Neuropsychological Evaluations
- \_\_\_\_\_ Psychiatric Evaluation
- \_\_\_\_\_ Special Education Data (e.g., 504 Plan, IEP)
- \_\_\_\_\_ Gifted Education Data (if separate from special education)
- \_\_\_\_\_ Other, Please Specify: \_\_\_\_\_

**Authorization**

This authorization is valid for one calendar year. It will expire on \_\_\_\_\_ [insert date]. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I recognize that health records, once received by the school, may not be protected by the HIPAA Privacy Rule, but will become education records protected by the Family Educational Rights and Privacy Act.

\_\_\_\_\_  
(Parent/Legal Guardian) (Date)

Please complete this form and mail to:  
The Sycamore School  
4600 N. Fairfax Drive Suite 300  
Arlington, VA 22203