



AUTHORIZATION FOR EXCHANGE OF INFORMATION

I authorize the following organizations, The Sycamore School, and

[Name of School/Organization]

[Phone]

[Email]

[Student Name]

[Date of Birth]

to release/exchange information and share communication in verbal, written, and/or electronic form regarding:

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 Signature:

Date:

Please complete this form and mail to:

The Sycamore School
4600 N. Fairfax Drive Suite 300
Arlington, VA 22203

www.thesycamorschoolva.org
EIN Number: 47-4551914
(703) 717-5360
info@thesycamoreschoolva.org