

Authorization to Release Information

**Sevier County School System
Department of Special Education**

320 Cedar Street
Sevierville, TN 37862
Phone: 865.453.1036
Fax: 865.453.3112

Student _____ Date of Birth ____/____/____
Parent _____ Phone (home) _____
(work/cell) _____
Address _____

_____ has been referred for an evaluation for Special Education Services. Any information or materials that may contribute to this assessment including, but not limited to, **Educational records** related to psychological assessments, diagnosis, recommendations, behavioral and progress reports. **Medical records** and information related to diagnosis, prescriptions, conditions, therapy and recommendations.

___ I give permission to release information about my child to the Sevier County School System for the dates of service of _____.

Please send to: **Department of Special Education** Phone: 865.453.1036
320 Cedar Street Fax: 865.453.3112
Sevierville, TN 37862.

___ I do not give permission to release information about my child to the Sevier County School System.

I understand that I can cancel this authorization at any time, but I understand that the cancellation will not affect any information that was already released before the cancellation. I understand that information about my case is confidential and protected by state and federal law. I approve the release of this information and understand what this agreement means. I am signing on my own and have not been pressured to do so. I understand that this authorization is valid for one year. I agree that the agencies and/or individuals listed below may share and exchange information about my child.

Parent/Guardian Signature _____
Date ____/____/____

Authorized School Employee Signature _____
Date ____/____/____

Agency and/or Person: _____
Address: _____
City, State, Zip Code: _____
Fax: _____