DrChiaradonna@hsseducation.com hsseducation.com

Authorization for Release and Exchange of Information

I, ____ (Please print) authorize and request the release of information between Dr. Chiaradonna and the identified individuals listed who will be planning and providing services for my child ____ (Print child's name)

The purpose of this authorization form is to enable Dr. Chiaradonna to better provide academic support services through coordinated service planning and delivery. In addition, this release will permit follow-up case coordination between individuals listed below (e.g., psychologists, counselors, etc.)

Identified Individuals

____ (PRINT NAME)

____ (PHONE & EMAIL)

____ (PRINT NAME)

____ (PHONE & EMAIL)

Parent Signature: _____________________________ Date: ____________

Student Signature: _____________________________ Date: ____________

*Please note: I will always speak with you prior to contacting any individual listed and you may always request a contact at any time. This permission will expire on ____________________

Anyone who does anything to help a child in life is a hero
-Mr. Rogers