Release of Information
Administrative Procedure 1.A.160C

I hereby authorize ***Evergreen School Division Student Services*** to receive/send/ exchange verbal and/or written information concerning:

Student Name	
Birth Date (dd/mm/yr)	

This includes but is not restricted to information related to education, speech/language, occupational therapy, physical therapy, psychology, psychiatry, social work, mental health, medical.

The sharing of this information will be used to facilitate educational planning. Written reports are kept in a confidential Student Services file.

Verbal and/or written information may be sent to/received from/ exchanged with:				
		Contact Name	Phone	FAX
	Pediatrician/Physician			
	Psychologist/Psychiatrist			
	Children's disABILITY Services			
	Child and Family Services			
	IERHA/Hospital			
	Other:			
	Other:			

It is my choice to give consent.
I understand this form will be in effect until the file is closed or until I withdraw my consent, in writing.

Parent/Guardian Signature:	
Date:	
Witness Signature:	
Date:	

(If student is 18 years or older, they may sign for themselves.)

This personal information will be used for the purpose of maintaining accurate and detailed student records for as long as it serves the educational needs of the student. It is protected by the Freedom of Information Act and the Protection of Privacy Act.

Evergreen School Division Student Services:	
Name:	
Job Title:	

If you have any questions, please call the ESD Learning Coordinator at 204 642 6260.