



Authorization for Release of Information

Child's name: _____

Date of birth: _____ Grade level of student: _____

Address: _____

I hereby give my permission for

_____ (name of agency/service provider)

_____ (agency/service provider address)

_____ (agency/service provider phone #)

to release/share the following information about my child with **Tennessee School for the Deaf LEA Outreach Services:**

Educational

Psychological

Audiological

Medical

Social History

Other _____

I understand that my child's records are protected under the FERPA law of confidentiality and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent, in writing, at any time except to the extent that action has been taken in reliance to it. This consent expires automatically one year from date of signature.

(Parent/Guardian Signature)

(Print Name)

(Date)