AP 3120-F2
Authorization for Release of Information Form

☐ I hereby authorize the Interlake School Division Student Services to receive/exchange written and/or verbal information including: educational, medical, social work, speech/language, occupational and physiotherapy, psychological, psychiatric or any other pertinent information concerning:

Student Name: Date of Birth:

The sharing of this information will be used to facilitate educational planning. Written reports will be kept in a confidential Student Services file. Written and/or verbal information may be received from/exchanged with:

☐ Pediatrician/Physician/Psychiatrist: Phone:

☐ Children's disABILITY Services: Phone:

☐ Child & Family Services: Phone:

☐ Hospital/IERHA: Phone:

☐ Other: Phone:

It is my choice to give consent. I understand that I may withdraw this consent at any time in writing to the Interlake School Division. This form will be in effect for two years from the date shown below or until the file is closed. Please check one of the following boxes:

☐ 2 years

☐ Until File Closes

Parent/Guardian Signature: Date:

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

Witness Signature (18 years or older): Date:

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 and Protection of Privacy Act. If you have questions or concerns about the collection, contact the Student Services Administrator, Interlake School Division, 192 2nd Ave. N., Stonewall, Manitoba, R0C 2Z0, 204-467-5100.

Requested by:

Clinician/Consultant