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Established 1868



Engage. Challenge. Achieve.

Columbia Campus
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AUTHORIZATION TO RELEASE STUDENT INFORMATION

- Occupational Therapy Evals/Notes
- Behavior Evals/Intervention Plans
- Audiology Evals/Notes
- Counseling Evals/Summary Notes
- Student Health Info/Treatments
- Staff Consultation
- Psychiatry Evals/Notes
- Psychology/Educational Evals
- Physical Therapy Evals/Summary Notes
- Individualized Education Program (IEP)
- Social Work Evals/Summary Notes
- Speech/Language Evals/Notes
- Entire Record
- Other: _____

CONCERNING: Student's Name: _____ (Please Print) DOB: _____

I AUTHORIZE:

TO RELEASE TO:

Name of sending person/organization

Name of recipient/receiving organization

Address

Address

City State Zip Code

City State Zip Code

E-mail Fax

E-mail Fax

FOR THE FOLLOWING PURPOSES:

- At my request
- School
- Legal
- Other

This authorization will expire on the following date: _____. The expiration date can be no longer than one year from today's date. If I fail to specify an expiration date, this authorization will expire in one year.

I understand that I may revoke this authorization in writing at any time except to the extent that Maryland School for the Deaf or its employees or agents have acted upon this authorization. My written revocation must be sent to the Office of Asst. Superintendent.

I understand that if the individual or organization authorized to receive information is not a school or health care provider and if such information is re-disclosed by the recipient, the released information may no longer be protected by federal privacy regulations, but may be protected under Maryland law.

I understand that this authorization is voluntary. I understand that I may receive a copy of this form after I sign it and that I may inspect and request a copy of the information that I am authorizing for use/disclosure.

Signature of Parent/Guardian: _____ Relationship to Student: _____

Print Name: _____ Date: _____