AUTHORIZATION FOR EXCHANGE OF INFORMATION

I authorize the following organizations, the Maverick Learning Center, and

Name of School/Organization *Phone* *Email*

Student Name *Date of Birth*

To release/exchange information and share communication in verbal, written, and/or electronic form regarding:

This information is to be used for educational evaluation and program planning.

Information for release includes the following: (Please Check)

- ☐ Grade/Report Card
- ☐ Standardized Test Results
- ☐ Health/Immunization Records
- ☐ Attendance Records
- ☐ Transcripts
- ☐ Discipline Records
- ☐ Psychological/Psychoeducational/Neuropsychological Evaluations
- ☐ Psychiatric Evaluation
- ☐ Special Education Data
- ☐ Gifted Education Data
- ☐ Other, Please Specifty:____________________________________

AUTHORIZATION

This authorization is valid for one calendar year. It will expire on ________________________ (insert date). I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I recognize that health records, once received by the school, may not be protected by HIPPA Privacy Rule, but will become education records protected by the Family Educational Rights and Privacy Act.

Parent/Legal Guardian Signature: Date:

Please complete and mail this form to:

Maverick Learning Center
www.mavericklearningva.com

935 First Colonial Rd
mcahoon@mavericklearningva.com

Virginia Beach, VA 23454