**Permission for Release of Records**

Physician, psychologist or other (specify) from whom records are being requested:

Name:

Address:

Phone:

I, , Parent/Guardian of , who is a student currently enrolled in Freeman Public Schools, hereby give my permission for release of the following records concerning my son/daughter:

The records should be sent to:

Staff member:

Title:

School:

Address:

Phone/Fax:

at your earliest convenience so that they may be used in the consideration of certain educational services. If you have questions concerning this request, please contact me at:

Parent/Guardian name:

Address:

Phone No.:

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Parent Signature Date