Authorization for Release and Disclosure and/or Request for Educational Information and Records

I, ___________________________________(parent's name), authorize *Apples of Gold Center for*

Learning to release or request information about __________________________________ (student's name) to of from the individual /organization listed below.

Name: ____

Name: ____

Name: ____

I understand that during the course of instruction at *Apples of Gold Center for Learning*, it may become necessary for *Apples of Gold* to consult with various persons, such as doctors, educators and other outside experts concerning my student. I authorize and consent to *Apples of Gold's* consultation with such professionals and experts on my student's behalf. I understand that in the course of such consultation, *Apples of Gold* may receive or give information that is of confidential nature.

I hereby authorize *Apples of Gold* to receive and give such information concerning my student that may be beneficial in the instruction of my student. I also authorize my student's physicians, educators and others who may possess confidential information concerning my student to divulge and deliver that information to *Apples of Gold.* Should I, at any time, wish to retain the confidential nature of any such information, I will advise in writing.

I agree that the information may be faxed or emailed for expediency. I have the right to revoke this authorization at any time. Any revocation will be done in writing and any information previously authorized and released will not be subject to revocation. I acknowledge and authorize that the information indicated on this form will be sent to the individual(s) / organization(s) listed above.

____ ________________________

Student/Parent/Guardian Signature Date