INFORMATION RELEASE

St Joseph's School for the Deaf

1000 Hutchinson River Parkway, Bronx, N.Y. 10465-1899

718-828-9000
TDD-828-1671
FAX-792-6631

DATE: _____

NAME OF STUDENT: _____ DOB: _____

PARENT/
GUARDIAN NAME: _____

I hereby authorize the release of these reports: [Check those appropriate]

- MEDICAL/HOSPITAL/CLINIC: _____
- PSYCHOLOGICAL: _____
- SCHOOL PHYSICAL/IMMUNIZATIONS: _____
- PSYCHIATRIC: _____
- SOCIAL SERVICE: _____
- SPEECH & HEARING: _____
- AUDIOLOGICAL: _____
- EDUCATIONAL: _____
- OTHER (Specify): _____

TO/FROM: ST. JOSEPH'S SCHOOL FOR THE DEAF

TO/FROM: _____
_____
_____

_____
SIGNATURE: PARENT/GUARDIAN

DATE OR EVENT ON WHICH THIS
AUTHORIZATION WILL EXPIRE: _____

I, Parent/Guardian, have the right to revoke this authorization at any time by writing to St. Joseph's School for the Deaf's Executive Director . I understand that I may revoke this authorization, except to the extent that action has already been taken based on this authorization.

Information disclosed under this authorization might be re-disclosed by the recipient and may no longer be protected by Federal or State Law.

☐ I have been provided a copy of this form.

[SJSD RELEASE FORM: REVISED: 11/05]