St. Peter Prince of Apostles School

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

Student Name: ____ Date of Birth ____________________________

St. Peter Prince of Apostles School is requesting that you authorize the release of specified records containing confidential information regarding the above student who is transferring to St. Peter Prince.

St. Peter Prince of Apostles School has permission to request records from:

School (required)
Name ____
Address ____
____ **Zip** ________________

Primary Physician
Name ____
Address ____
____ **Zip** ________________

Psychiatrist / Psychologist
Name ____
Address ____
____ **Zip** ________________

RECORDS TO BE REQUESTED

Transcript	***ARD/IEP - Required if Available***
Medical/Immunization Records	***Academic Assessment - Required if Available***
OT/PT Assessment	Psychological Assessment
Vision/Hearing Screenings	Speech Language Assessment
Discipline File	Comprehensive Assessment

_____ Yes _____ No I have been fully informed and understand the school's request for my consent for release of the student's records as described above. This information will be released upon receipt of my written consent.

_____ Yes _____ No I understand that my consent is voluntary and may be revoked in writing at any time.

_____ Yes _____ No I grant consent for release of records as specified above.

Parent Signature: ____ **Date:** ______________________________

Please Mail to:

St. Peter Prince of Apostles School
112 Marcia Place, San Antonio, TX 78209
(210) 824-3171