

MARDAN CENTER OF EDUCATIONAL THERAPY

AUTHORIZATION FOR RELEASE OF STUDENT INFORMATION

Re: _____

Birth date: _____

I hereby authorize Mardan Center of Educational Therapy to

_____ Release information to:

_____ Request information from:

Agency, Doctor, etc. () Telephone Number

Street Address

City State Zip Code

I, the undersigned parent, guardian, or student (if 18 years of age or older) understand that I have the right to review the above requested information and receive a copy of any materials forwarded.

Parent/Guardian Signature Relationship

Street Address City State Zip

() _____
Telephone Number Date

Mardan Only:

I certify that the information received will be used only to assist the Mardan Center of Educational Therapy and will not be copied for transmission to others without signed parent/guardian authorization.

Mardan Administration Signature Date