Daviess-Martin Special Education Cooperative
P.O. Box 637
Washington, IN 47501
(812) 254-1530 Fax (812) 254-1636

Authorization for Reciprocal Release of Information

Name_____ Date_____

Birth Date_____ SSN_____

I hereby authorize the exchange of information between:

Daviess-Martin Special Education Cooperative
P.O. Box 637
Washington, IN 47501

and: _____

_____

_____

All information regarding services rendered during the period(s): _____

_____

I understand this may include psychological, social, medical, and educational information. I understand that this information is confidential and will be treated as such. Permission is also given to exchange information verbally, over the phone or in person. This permission will remain in effect for one (1) year from the date signed unless the parent withdraws this permission in writing.

_____ _____
Parent/Guardian/Surrogate's Signature Date

_____ _____
Witness' Signature Date

Revised November 2002