School Administrative Unit Number Nine

Department of Special Services

Serving Albany Bartlett Chatham Conway Eaton Hart's Location Jackson

AUTHORIZATION TO EXCHANGE INFORMATION

Case Manager _____ Phone _____ Today's date _____
Student Name _____ DOB_____School _____
Parent's Name_____
Parent's Address _____ City_____State ___ Zip _____
Phone _____

SAU 9 would like to exchange your child's information and need your consent to do so. The purpose of this request is for educational planning.

The following information will be exchanged:

▢ Any and All ▢ Cumulative School Information ▢ Guidance Information
▢ Educational Information ▢ Medical/Health Information ▢ Evaluation Information
▢ Special Education Information ▢ Other _____

Information will be exchanged with (doctor, agency or other school): _____
Contact person _____
Address_____City_____State___Zip _____
Telephone Number _____

Person requesting exchange:

Name_____ Title _____ Phone _____

Your consent may be revoked at anytime except for information disclosed prior to revocation. This consent expires one year from the date of consent unless otherwise specified.

▢ I give my permission to have information on my child exchanged as indicated above.
▢ I refuse permission to have information on my child exchanged as indicated above.
▢ I would like to talk to someone at the school before making my decision.

Signature (parent/guardian/adult student) _____

Date _____