

# CONSENT FORM FOR MUTUAL EXCHANGE OF INFORMATION

Date \_\_\_\_\_

Student's Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ ID# \_\_\_\_\_

I hereby authorize the mutual exchange of records pertaining to my child or myself, \_\_\_\_\_, between the MIAMI-DADE COUNTY PUBLIC SCHOOLS and the following agencies (include all schools, physicians, psychologists, hospitals, clinics, etc., that have had significant contact with your child):

Name

Address

<u>Name</u>	<u>Address</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

• The specific records to be disclosed pertain to: \_\_\_\_\_

• The purpose for making these records available is: \_\_\_\_\_

• **The receiving party will not disclose the information to any other party without signed consent.**

I certify that I am the parent or legal guardian of the child named above or that I am a student of majority age and have the authority to sign this release.

_____	_____	_____
Name (print)	Signature	
_____	_____	_____
Address	City, State	Zip Code

Please return this form to: