Serving Families and Children with Unique Abilities!

Consent for Release & Review Student Confidential Information

Records & Consent for Communication to:
Dr Walker's Learning Academy
Dr. Belinda McNeal Walker M.S.,Ed.D
belindamcnealwalk@att.net
(772)240-4178

Student Information: Please release educational/medical records for the following student:

Name: _____ DOB: _____

Address: _____

Please provide the following records: __Educational __Medical

_____

_____

_____

Parent Information:

Print Parent Name: _____ Phone: _____

Address: _____

Email Address: _____ Parent Signature: _____
Date ___/___/___ *IN WITNESS WHEREOF, I/WE have carefully read and understood all terms of this Release of Confidential Information and indicate with my/our signature voluntary execution of this Agreement.* I hereby authorize the release of confidential information and the exchange of records pertaining to the above student with Dr. Walker's Learning Academy and the named party listed below. This agreement will terminate within 360 calendar days following the parents signature date noted above. This agreement may be revoked at any time by written request except if the disclosing agency has taken action in reliance on it.

Records & Consent for Communication From:

School/Office: _____

Address: _____

Phone: _____ Fax: _____

Email: _____