



SCHOOL DISTRICT NO. 34 (ABBOTSFORD)

2790 Tims Street, Abbotsford, BC, V2T 4M7

Phone No. 604-859-4891

Fax. No. 604-852-8587

Student Records

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I _____ hereby give my

written consent to have _____

(Name of previous school district or agency)

(Address)

release the student folder, permanent record card and all pertinent medical, psychological, or psychiatric (including social history, all hospital testing and assessments) information which pertains to my child,

Name _____ D.O.B. _____

to _____

(Name of receiving school district or agency)

at _____

(Address)

I also give consent to allow above said agency to share information with :

(Name of receiving school district or agency)

I furthermore release all parties stated here within from any legal liability resulting from the release of this information, with the understanding that all parties involved will exercise sufficient safeguards while using this information.

Signature: _____

Address: _____

Phone No.: _____

Date: _____