

**THE SCHOOL DISTRICT OF PHILADELPHIA**  
440 NORTH BROAD STREET  
PHILADELPHIA, PA 19130  
(215) 400-4000

**RELEASE OF INFORMATION**

\_\_\_\_\_  
Student Name (Last, First)

\_\_\_\_\_  
School Name

\_\_\_\_\_  
Student ID #

\_\_\_\_\_  
Date of Birth

In order to provide/receive information regarding your child, The School District of Philadelphia needs your written permission.

If you give permission, copies of the information will be given to and/or received by the party named below:

Agency/Employee: \_\_\_\_\_

Types of information to be shared:

Educational

Neurological

Speech/Hearing

Psychological

Medical

Psychiatric

Other \_\_\_\_\_

Other \_\_\_\_\_

**Certification**

I certify that I am the parent, legal guardian, or appointed educational surrogate of the student listed above. I, hereby, give permission for the release of information requested. I am aware of my legal rights regarding the release of personally identifiable information, including my right to withdraw permission and to get copies of the information upon written request. I understand that this permission is valid only for the items stated above and for the current school year ending 20\_\_.

Full Name (Print): \_\_\_\_\_ Relationship to Student: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_