THE SCHOOL DISTRICT OF PHILADELPHIA

Office of Student Rights and Responsibilities
Deputy Chief, Lori Paster MS, LBS
440 North Broad Street
Philadelphia, PA 19130
Suite 243, Portal D
Telephone (215) 400-6791
Fax (215) 400-4226

_____
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

□ Speech/Hearing

□ Medical

□ Other _____

□ Neurological

□ Psychological

□ Psychiatric

□ Other _____

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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:_____