Pearl River School District
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Carloyn M. Moffa
Director of Special Services

RELEASE OF CONFIDENTIAL INFORMATION

Date: ______________________________

To: ____

I give permission for ____

to exchange confidential information regarding

______________________________ With ______________________________
Student's Name Therapist/Agency

I understand that confidential information may include academic, psychological, psychiatric and medical records.

______________________________ ______________________________
Parent/Guardian (please print) Signature of Parent/Guardian