

**darien public schools • administrative offices**  
**p.o. box 1167 • darien, connecticut 06820-1167 • tel. (203) 656-7421**

I give permission to the Darien Public Schools to release / receive (**please circle**) the following

records of my child, \_\_\_\_\_  
Name of Child Date of Birth

**Release to:**

**Receive from:**

\_\_\_\_\_  
Specific Party  
\_\_\_\_\_  
Agency  
\_\_\_\_\_  
Address  
\_\_\_\_\_  
City • State • Zip Code

\_\_\_\_\_  
Specific Party  
\_\_\_\_\_  
Agency  
\_\_\_\_\_  
Address  
\_\_\_\_\_  
City • State • Zip Code

- Issue to Parents copies of the following confidential documents  
 Send / discuss the following confidential documents with : \_\_\_\_\_

**Please check  documents / information you wish to be released:**

- Educational Records  
 Individual Educational Programs (IEP)  
 **Medical Records**  
     Psychiatric                       Audio Logical                       School Health Record  
     Physical Therapy                       Occupational Therapy                       Physician  
 Psychological Evaluations  
 School Transcript  
 Speech/Language Evaluations  
 Other: \_\_\_\_\_

**Reason for Release:**

\_\_\_\_\_  
**Parent Signature** **Date**