OFFICE OF SPECIAL SERVICES
P.O. Box 450 • Vernon, NJ 07462
Voice (973) 764-2935 • Fax (973) 764-0078

AUTHORIZATION FOR RELEASE/EXCHANGE OF INFORMATION

Student's Name_____ School_____

I authorize the following persons to exchange verbal and written information concerning the above student. If the student is in need of bedside instruction and a doctor's note has been submitted, only the school physician will engage in follow-up if it is necessary.

NAME & TITLE _____
ADDRESS _____
EMAIL AND PHONE # _____

NAME & TITLE _____
ADDRESS _____
EMAIL AND PHONE # _____

The following information (including reports) will be exchanged:

☐ All special education files included with IEP

☐ Other: 504 Documentation with Medical explanation if applicable

This release will be valid for the school year(s) checked below: _____

☐ 2021-22 ☐ 2022-23 ☐ 2023-24

Relationship to student:_____Parent/Guardian Signature_____ _____
Please Print Parent/Guardian Name_____Date_____

Relationship to Adult Student:_____Parent/Guardian Signature_____
Please Print Parent/Guardian Name_____Date_____

INFORMATION SHOULD BE EMAILED TO LISA CURRY AT LCURRY@VTSD.COM