BrainSTEPS

Strategies Teaching Educators, Parents, & Students

A BRAIN INJURY SCHOOL RE-ENTRY CONSULTING PROGRAM

LUZERNE INTERMEDIATE UNIT #18

AUTHORIZATION TO REQUEST/RELEASE CONFIDENTIAL INFORMATION to the LIU18 Brain STEPS Team:

I, ____, of _________________________________

Parent/Guardian/Surrogate Street

______________________________________, hereby authorize the LUZERNE Intermediate

City State Zip

Unit #18 to release/obtain records and information regarding my child/ward:

____ ______________________

Name of Student Date of Birth

Please include name, phone number and fax number (if available) for the following as appropriate:

1. Primary Physician: ____
2. Neuro-Psychologist:____
3. Other: ____

Please initial specific reports, records, and/or telephone contacts to be released to the LIU 18 Brain STEPS Team:

Reports:	*Educational Records:*	*Phone conversations with:*
___ Psychological	___ ER/RR	___ Physician
___ Psychiatric	___ IEP	___ Psychologist
___ Medical	___ Educational Assessments	___ Neuro-Psychologist
___ Speech		___ OT/PT/Speech
___ OT/PT		
___ Vision	Other: ____	
___ Audiological	____	

This authorization will expire one calendar year from the date below.

Updated 6/08

Signature of Parent/Guardian/Surrogate

Date