

LEXINGTON PUBLIC SCHOOLS

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CONSENT FORM FOR MUTUAL EXCHANGE OF INFORMATION

PURPOSE: To obtain parental permission to secure necessary child records from agency and/or personnel outside the school district.

Date: _____

Student's Name: _____

Date of Birth: _____

I hereby authorize the mutual exchange of records regarding the above named child between the School District and (list of all schools, physicians, psychologists, hospitals, clinics, etc. that have had significant contact with your child.) **Please provide name, address, and phone number if you can:**

Name: _____

Address: _____

Telephone: _____

I certify that I am the parent or legal guardian of the above named child or that I am the student of majority age and have the authority to sign this release.

Signature: _____

Address: _____

Telephone: _____