Allyson Carlson Psy.D.
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6144 Route 25A Suite 23-24
Wading River, New York, 11792
631.708.5945

Consent for Release/Exchange of Student Records and Information

Student's Name: _____ Date of Birth: _____/_____/_____

I hereby give permission to release/exchange copies of and/or share information contained within the Student's school student records listed below:

_____All School Student Records, including but not limited to:Cumulative, permanent record, special education records, grade reports, discipline records, health records,attendance records, test scores, copy of birth certificate, etc.
_____All Special Education Records
_____Specific School Student Records
(checked below):
___Medical Information
___Social Histories
___Psychological Evaluations
___Psychiatric Evaluations
___IEP
___Speech/Language Evaluations
___Health/Attendance records
___Birth Certificate
___Physical Therapy Evaluations
___Test Scores
___Occupational Therapy Evaluations
___Cumulative
___Permanent Record
___Copy of Physical for Athletics
___Other: _____

This information is to be released/exchanged between:

School/Agency:_____
Attn: _____
Address: _____

AND

Dr. Allyson Carlson
6144 Route 25 A Suite 23, Wading River, NY 11792

Parent/Guardian Signature_:_____
Date: _____