THE MADDUX SCHOOL
11614 Seven Locks Road ♦ Rockville ♦ Maryland 20854 ♦ 301-469-0223 ♦ www.madduxschool.org

AUTHORIZATION TO RELEASE INFORMATION

I, _____, hereby authorize the following professionals and staff of The Maddux School to exchange designated information concerning my child:

_____
Name of Child

Name: _____ Name: _____

Agency: _____ Agency: _____

Address: _____ Address: _____

_____ _____

Tele: _____ Tele: _____

____ Speech/Language Evaluation
____ Occupational Therapy Evaluation
____ Educational Assessment
____ Psychological Evaluation
____ Psychiatric Evaluation
____ Other: _____

____ Medication Evaluation
____ Physical Examination
____ I.E.P.
____ Neuropsychological Evaluation
____ Psychosocial Assessment

This information will be used for the purpose of planning and implementing programs. I understand that I may withdraw my consent at any time.

_____
Parent/Guardian (Print Name)

_____ _____
Parent/Guardian Signature Date

05/16