

**THE MADDUX SCHOOL**

11614 Seven Locks Road ♦ Rockville ♦ Maryland 20854 ♦ 301-469-0223 ♦ [www.madduxschool.org](http://www.madduxschool.org)

**AUTHORIZATION TO RELEASE INFORMATION**

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

\_\_\_\_\_  
Name of Child

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Agency: \_\_\_\_\_

Agency: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_  
Tele: \_\_\_\_\_

\_\_\_\_\_  
Tele: \_\_\_\_\_

Email: \_\_\_\_\_

Email: \_\_\_\_\_

- 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. Unless otherwise specified, this Release expires one year after signed date.

\_\_\_\_\_  
Parent/Guardian (Print Name)

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date