Herricks Public Schools Union Free District 999 Herricks Road New Hyde Park, NY 11040

OFFICE OF PUPIL SERVICES

Parent / Guardian / Surrogate Consent Form For: Request / Release of Information

Student: Last Name _____ Date of Birth: ____/____/___

First Name _____ Phone: Home:_____

Address: _____ Phone: Work: _____

_____

I authorize the right of the two parties listed below to release and share information regarding the above named student. This information may include test results (e.g., medical, psychiatric, psychological) evaluations, reports and any other pertinent information.

Herricks School District and _____
New Hyde Park, NY 11040

_____

_____

_____

_____

I understand I may revoke this consent at any time and that the above-named receiver of this information has the right to inspect and copy the information to be disclosed.

This consent is valid:

__ Until the end of the current school year _____

__ For six months from date of consent.

__ For one year from date of consent.

__ Other _____

Parent / Guardian Signature: _____

Date Of Consent : _____

Rev. 5/12