The IDEAL School of Manhattan

AUTHORIZATION FOR RELEASE OF INFORMATION

Please complete, sign and return this form with the application.

Full name of applicant: _____Date of birth:_____

I authorize the following professionals to provide any pertinent and confidential information regarding my child's medical, psychological, developmental, physical, and academic functioning with The IDEAL School of Manhattan, as part of my child's application for admission to that school for the _____ school year. I understand that the information requested is for professional use and will remain confidential.

School Principal/ Director/ Guidance Counselor	Name:	Phone: Email:
Psychologist/ Therapist/Social Worker	Name:	Phone: Email:
Evaluator/ Ed Consultant	Name:	Phone: Email:
Attorney/ Advocate	Name:	Phone: Email:
Related Service Provider (Speech/language, OT, PT, etc.)	Name:	Phone: Email:
Additional professionals not listed above	Name:	Phone: Email:

Signature of Parent / Guardian: Date:

Name of Parent / Guardian (please print):