



Consent to Obtain and/or Release Information

With regard to:

Student Name: _____	D.O.B. (mm/dd/yy): ____/____/____
School: _____	Student ID: _____

I, _____, give my consent for the following person/agency:

Name of Person/Agency: _____
 Street Address: _____
 City/Prov./Postal Code: _____
 Phone Number: _____

to obtain (specify information) _____ **from:**

Name of Person/Agency: _____
 Street Address: _____
 City/Prov./Postal Code: _____
 Phone Number: _____

to release (specify information) _____ **to:**

Name of Person/Agency: _____
 Street Address: _____
 City/Prov./Postal Code: _____
 Phone Number: _____

I understand:

- (a) the period of consent will terminate one year from the date it was granted as indicated below;
 - (b) the nature and purpose for which this information is being obtained/released/exchanged;
 - (c) this information will be used for the planning and provision of educational services;
 - (d) that I may revoke my consent at any time;
 - (e) this information will be treated confidentiality;
 - (f) that a copy of all information will be made for the confidential files at the UCDSB regional office.
- (g) this information will be placed in the OSR. My initials here _____ indicate that consent for this is NOT given.**

Signature: _____ Relationship to Student: _____

Phone #: _____ Date: _____

Witness Signature: _____ Witness Phone #: _____