



**CONSENT TO RELEASE
and
EXCHANGE OF INFORMATION
Third Party (outside) Assessment Reports**

STUDENT NAME:	D.O.B.: (dd/mm/yy)
SCHOOL:	STUDENT I.D.#:

Report Completed by: (Name of assessor or institution)	Report Dated: (dd/mm/yy)
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Please read and initial the appropriate area(s), and sign below.

_____ (Initials)	As parent/legal guardian, I give permission for the attached assessment report to be included in the Ontario Student Record (OSR) of the student named above for the purpose of assisting in educational programming.
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_____ (Initials)	As parent/legal guardian, I give my consent for the school named above to make one (1) copy of this report and send the copy to the UCDSB Regulated Health Professional named below. The report will be filed in secure and confidential regional files in accordance with Ministry of Health Regulations, in order to assist regional staff in educational programming.
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_____ (Initials)	As parent/legal guardian, I give my consent for the mutual sharing of verbal and/or written information between the UCDSB Regulated Health Professional (named below), the author of the report, and the school named above, for the purposes of educational programming.
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Name of UCDSB Regulated Health Professional

_____ (circle one: Psychology Services/Speech Language Services)

The above has been explained to my satisfaction, and is clearly understood by me.

(Parent/Legal Guardian of student under 18 years of age)

(Relationship to student)

(Student 12 years old or over)

(Witness)

(Date)

(Location)