**Consent to Release Information**

 I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, give permission for Christina O’Brien,

 (Parent/Guardian’s Name)

 Special Services Manager, to obtain information regarding my child,

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. Information may be obtained from

 (Child’s Name)

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and may include (please check below):

 (Service Provider/ School District)

\_\_\_\_\_\_\_\_\_\_ Child’s IFSP/IEP

\_\_\_\_\_\_\_\_\_\_Information to Early Head Start/Head Start Staff

\_\_\_\_\_\_\_\_\_\_Obtain Therapy Notes

\_\_\_\_\_\_\_\_\_\_Release Child’s Evaluation

Please mail or fax a copy to:

Christina O’Brien

Education Services Manager

2328 5th Ave

Troy, NY 12180

W: (518) 272-6012 ext. 220

clobrien@ceoempowers.org

**This consent is valid from the date of signature; unless I notify a CEO staff member in writing that I no longer want this consent to be active. Effective until August 2026.**

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