Lake Minnetonka Psychology
202 Water Street, Suite 208
Excelsior, MN 55331
Contact: Kathleen Petersen, Ph.D., LP, NCSP
KP@LakeMinnetonkaPsychology.com
612-895-6500

CONSENT TO RELEASE & EXCHANGE EDUCATIONAL INFORMATION

I want the following information shared with Dr. Kathleen Petersen for educational planning and/or service coordination. By signing this form, I am allowing service providers or agencies to exchange information that will be useful in planning current treatment, and/or will make it easier for them to work together effectively in planning and/or providing services.

____ _________/_______/_______
(Please Print Full Name of Client Legibly) (Client's Date of Birth)

My relationship to the client is: Self Parent Guardian

I want the following information between the dates of ___________ and _____________ about the client to be exchanged:

_____ School Report Cards
_____ School Transcript
_____ Standardized Test Results
_____ Special Education Evaluations (if applicable)
_____ Most recent Special Education IEP and progress report (if applicable)
_____ Teacher/educator verbal or written report regarding client's learning and behaviors at school

I authorize Dr. Kathleen Petersen to call and/or send information via mail to those below:
YES NO

I want Dr. Kathleen Petersen and the following providers/agencies to exchange this information:
(Please fill in names and provide telephone numbers if you have them.)

Educational Institution ____

Individual(s) ____

Other ____

Records should be:

____ Held at school agency office for pickup by parent/guardian
____ Sent home with student
____ Emailed to parent/self (if age 18 or older) ____
Email address/agency/individual
____ Mailed via USPS to ____

____

____

_____ Other (please specify) ____

Expiration & Terms: I understand that this consent is good until one year from the date of my signature (except as otherwise allowed by law or for a period that is specified in the date following this paragraph). In addition, I understand that information may be shared in writing, via email, in computerized form, and/or in meetings or by telephone.

Expiration Date (circle one): One year from date signed or ________________________
(Date)

Revocation: I understand that I can withdraw this consent at any time. The revocation will not apply to information that has already been released. I must revoke this Consent in writing to Dr. Kathleen Petersen. This will stop the listed parties from sharing information after they know my consent has been withdrawn. I have the right to know what information has been shared, and why, when, and with whom it was shared if I ask. I want the parties listed above to accept a copy of this form as consent to share information.

Statement of understanding: By signing this document, I am agreeing I have been told and understand the nature and purpose of the authorized release.

____ _________/________/________
(Client or Parent/Guardian Signature if under 18) (Date Signed)