

Authorization to Release/Obtain information

Dear Counselor,

Below is a record's request form for the student named below. We are in the process of performing an evaluation on this student so that we may better address academic strengths and weaknesses. We would appreciate your prompt release of the student's records so we may quickly begin providing educational assistance.

Thank you.

RECORDS RELEASE REQUEST

Student's name

Birth Date

Student's address

Telephone

SCHOOL RELEASING INFORMATION

AGENCY OBTAINING INFORMATION:

NAME _____

TOTAL LEARNING CONCEPTS, INC.

3981 Atlanta Highway 78, Ste. 3

Loganville, GA. 30052

(770) 466-8282

Fax (770) 466-7792

TYPE OF MATERIAL:

_____ Most recent IOWA or COGAT test results

_____ Other school testing

_____ Student transcript

_____ Other

REASON:

_____ Academic evaluation to individualize a program of remediation or enrichment

_____ I hereby authorize **Total Learning Concepts**, to obtain academic information concerning the above named student and the school to release this information.

I also authorize my child's physicians, educators, and others who may have academic information concerning this student to provide information to **Total Learning Concepts**.

Physician _____

School Counselor _____

Psychologist/Psychiatrist _____

Teacher _____

Course _____

Teacher _____

Course _____

Parent/Guardian Signature

Date