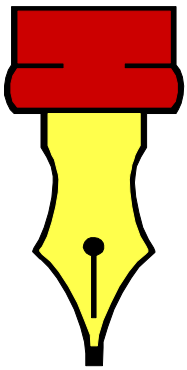

Magnum Opus Education Center

RELEASE OF INFORMATION

Date
To

_____

From_____

I, _____, authorize Kathy N. Bishop/Magnum Opus Education Center, LLC, to receive/send information regarding my child,

_____

INFORMATION:

_____ Medical

_____ Intellectual/Psychological

_____ Educational

_____ Psychiatric

_____ Social History

_____ ESE Student Records

_____ Any information that may be helpful in diagnosis, service eligibility consideration, and/or intervention planning

All information received by Kathy Bishop/Magnum Opus Education Center shall be used for legitimate purposes, and confidentiality of all client records shall be maintained in accordance with applicable federal and state law. Further, the undersigned authorizes Kathy Bishop to release the above-stated records only for the following purposes:

_____

_____ _____

Signature of Parent/Guardian Date