



## Special Services

300 Clinton Avenue, Clover, SC 29710

803-810-8400 (telephone)

803-222-8043 (fax)

**2026-27**

### **Permission to Release/Obtain Confidential Information**

Student: \_\_\_\_\_ DOB: \_\_\_\_\_

***This section must be filled in completely.***

I hereby authorize Clover School District to release/obtain information to/from:

Name of Facility: \_\_\_\_\_

To the Attention of: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Email: \_\_\_\_\_

*(Include email address if this is your preferred method of transmission.)*

The above individual is a student enrolled and/or residing in the Clover School District. I am the parent/legal guardian of the student named above. I give my permission for Clover School District and the above individual or agency to release, obtain, use, and exchange the following confidential information. I understand the information will be used and/or considered in educational evaluation and/or educational program development. Verbal communication will only consist of information checked below.

Check all that apply:

- \_\_\_\_\_ Individualized Education Program/504
- \_\_\_\_\_ Psycho-Educational Evaluation
- \_\_\_\_\_ Speech Screenings/Evaluation
- \_\_\_\_\_ Hearing/Vision Screenings
- \_\_\_\_\_ Assessments/Rating Scales/Questionnaires

\_\_\_\_\_  
Signature of Parent/Legal Guardian/Student (if over 18 years)

\_\_\_\_\_  
Date