



ASD-W
Anglophone School District West

POLICY NO. ASD-W-350-3A

**Inclusive Education – Accessing Education Support Services
Appendix A – Consent to Release/Obtain Personal Information**

CONSENT TO RELEASE / OBTAIN PERSONAL INFORMATION

Student's Name:	Medicare #:			
School:	Grade:			
Home Address:	Date Of Birth:			
		(m)	(d)	(y)
Parent / Guardian Name:				

By signing below, I confirm that I have discussed, read and agree with the following:

Purpose of Information: I understand that information is being shared to better understand my child's strengths and needs for the purposes of determining appropriate academic and behavioural supports and services for my child in school.

Storage of Information: The information being shared is confidential and safeguarded to ensure security and prevention of unauthorized access, use and disclosure.

Length of Consent: I understand that my consent for sharing information is valid for **one year** from the date of my signature and that I have the right to cancel my consent at any time.

Permission is granted to _____ to release/obtain information and reports from the following agencies / individuals regarding my child:

Agency / Individual	Release	Obtain	Both
Name:	☐	☐	☐
Name:	☐	☐	☐
Name:	☐	☐	☐

Parent / Guardian Signature:	
Date:	