

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.
2700 Braselton Highway, Ste. 3
Dacula, GA. 30019
(770) 271-7544
Fax (770) 271-7546

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
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