



**Permission to Observe/Dialogue/Release Records**

I/we hereby give permission for the release of the following information on:

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

**I. Permission to observe student in current setting:** Yes \_\_\_\_\_ No \_\_\_\_\_

Setting to be observed: \_\_\_\_\_

**(Pathway staff: if outside professionals are observing a student at The Pathway School, Community Support Provider Procedure should be initiated)**

**II. Permission to engage in dialogue:** Yes \_\_\_\_\_ No \_\_\_\_\_

\_\_\_\_\_  
Name of professional                      Organizational association                      Phone number/email

\_\_\_\_\_  
Name of professional                      Organizational association                      Phone number/email

\_\_\_\_\_  
Name of professional                      Organizational association                      Phone number/email

**III. Permission to release records to:**

\_\_\_\_\_  
Name of professional                      Organizational association                      Address/email

\_\_\_\_\_  
Name of professional                      Organizational association                      Address/email

Education records: \_\_\_\_\_

Medical/Hospital records: \_\_\_\_\_

Results of testing: \_\_\_\_\_

Clinical/Psychiatric records: \_\_\_\_\_

Social service records: \_\_\_\_\_

Other: \_\_\_\_\_

**IV. Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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

Please be advised that regardless of any designation thereon of "private and confidential", any information received may become a part of a student's education record and be subject to review by the student's parents/guardian pursuant to the Family Educational Rights and Privacy Act.

-----For School Use-----

Please forward to: Pathway Employee: \_\_\_\_\_

Phone: 610-277-060 ext \_\_\_\_\_ Email: \_\_\_\_\_

**Please use reverse side for additional professionals**



**Please use this side for additional professionals**

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

**II. Permission to engage in dialogue:** Yes \_\_\_\_\_ No \_\_\_\_\_

\_\_\_\_\_  
Name of professional                      Organizational association                      Phone number/email

\_\_\_\_\_  
Name of professional                      Organizational association                      Phone number/email

\_\_\_\_\_  
Name of professional                      Organizational association                      Phone number/email

\_\_\_\_\_  
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**III. Permission to release records to:**

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Name of professional                      Organizational association                      Address/email

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\_\_\_\_\_  
Name of professional                      Organizational association                      Address/email

\_\_\_\_\_  
Name of professional                      Organizational association                      Address/email

\_\_\_\_\_  
Name of professional                      Organizational association                      Address/email

- Education records: \_\_\_\_\_
- Medical/Hospital records: \_\_\_\_\_
- Results of testing: \_\_\_\_\_
- Clinical/Psychiatric records: \_\_\_\_\_
- Social service records: \_\_\_\_\_
- Other: \_\_\_\_\_

**IV. See reverse side for parent/guardian signature**

Please be advised that regardless of any designation thereon of “private and confidential”, any information received may become a part of a student’s education record and be subject to review by the student’s parents/guardian pursuant to the Family Educational Rights and Privacy Act.