Special Services
300 Clinton Avenue, Clover, SC 29710 803-810-8400 (telephone) 803-222-8043 (fax)

2022-23
Permission to Release/Obtain Confidential Information

Student: ______________________________________ DOB: __________________

I hereby authorize Clover School District to release/obtain information to/from:
(This section must be filled in completely.)

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.

_____ Individualized Education Program
_____ Speech Screenings/Evaluation
_____ Medical Information
_____ Achievement Testing, School Records
_____ Psychiatric Evaluation/Treatment
_____ Home School Information
_____ Psycho-Educational Evaluation
_____ Social/Developmental History
_____ Observations
_____ Mental Health Services
_____ Juvenile/Truancy Information
_____ Medicaid Referrals/Evaluations
_____ Other: ____
_____ Other: ____

____ ____________________

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