AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize: *Inclusive Learning S*chool District #79 (Cowichan Valley) to release the confidential/special file(s) of the following student:

Student Name: _____

Date of Birth: _____

To: _____

Address: _____

Telephone: **Fax:** _____

E-Mail: _____

_____ _____

Parent / Guardian Signature Date

_____

Please print name of Parent/Guardian

Please send completed form to
Inclusive Learning by
email: sss-2@sd79.bc.ca or fax: 250-748-4617