



CONSENT FOR RELEASE OF RECORDS AND PROFESSIONAL COMMUNICATION

STUDENT'S NAME: _____

DATE OF BIRTH: _____ **CURRENT GRADE:** _____

CONTACT INFORMATION: Please enter the primary phone number for each parent/guardian.

Parent/Guardian #1 Name: _____ Phone: _____

Parent/Guardian #2 Name: _____ Phone: _____

I, _____, authorize the release of my child's academic and health related records and information to/ from each of the following schools, individuals, agencies and/or institutions:

Source/Contact Person	Phone/Fax	Address	Email

I understand that the information obtained is considered confidential and will be used by proper authorized professionals of MEF International School for the purposes of admissions consideration, academic placement, program and support planning, accommodations consideration and/or professional communication between relevant members of MEF's student support team and the providers listed above on behalf of my son/daughter. **Please Return to the Related School Provider.**

Signature date is the effective date of authorization.

I understand that to revoke this authorization, I must put the request in writing to my child's principal and counselor at MEF International School. This authorization will automatically expire thirty (30) days after the end of the current academic year.

Parent/Guardian Signature : _____

Parent/Guardian Name: (Print) _____ Date: _____

Student Signature if 18 years old: Signature _____

Student Name if 18 years old: (Print) _____ Date: _____