Lawrence School

CONSENT FOR RELEASE OF INFORMATION

Student Name _____

Address _____

City _____ State _____ Zip _____

I hereby give permission for Lawrence School to release to, receive from and communicate with the following (choose one professional per release form):

_____ Pediatrician _____ Psychiatrist _____ Psychologist _____ Counselor

_____ O.T. _____ Speech Pathologist _____ Other _____

Name _____

Address _____

City _____ State _____ Zip _____

Telephone # _____ Email _____

Fax _____

_____ _____

Parent/Guardian Signature Date

_____ _____

Lawrence School Representative Signature & Title Date

Please forward all information to:
Lawrence School – Lower Campus
1551 East Wallings Road, Broadview Heights, OH 44147
Phone: 440-526-0003
Fax: 440-526-0595