



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 – Upper Campus
10036 Olde Eight Road, Sagamore Hills, OH 44067
Phone: 330-908-6800
Fax: 330-908-7006