REQUEST FOR MUTUAL EXCHANGE OF INFORMATION

Occasionally, it is essential to exchange information with authorized agencies and/or physicians to effectively assist your child. It is necessary to secure parental permission prior to requesting information. Please complete this form and return it in the enclosed envelope. Thank you for your cooperation.

Sincerely,

Special Education Department
Mt. Pleasant Public Schools

Date: ______________________________

I authorize the following agency/physician to release information concerning my child to:

Mt. Pleasant Public Schools
Special Education Department
720 N. Kinney Avenue
Mt. Pleasant, MI 48858

Child's Name:	Date of Birth:
Agency/Physician Name:	
Agency/Physician Address:	
Agency/Physician Telephone:	

THE FOLLOWING INFORMATION IS REQUESTED:

- ☐ IEPC Report(s)
- ☐ MET/MDT Certification(s)
- ☐ Psychological/Psychiatric Report(s)
- ☐ Achievement Test Report(s)
- ☐ Medical/Physician's Report(s)
- ☐ Health/Immunization Record(s)
- ☐ Social/Developmental History
- ☐ Speech/Language Report(s)
- ☐ Vision Report(s)
- ☐ Hearing Report(s)
- ☐ School Social Work Report(s)
- ☐ Therapy Summary
- ☐ Other ____

Parent/Guardian Signature:
Parent/Guardian Address:
Date: