Release of Information

*The purpose of sharing information is to better inform those working with your child, so that they may provide the best possible programs and services.*

I, hereby authorize Horizon School Division No. 67 to

Parent/Guardian

release information for my child, , born Student mm/dd/yyyy

in accordance with the Freedom of Information and Privacy Act, to and from:

|  |  |
| --- | --- |
|  |  |
|  | Family Doctor |
|  |  |
|  | Medical Agencies, e.g. CAHS, Mental Health Services, Alberta Children’s Hospital |
|  |  |
|  | Social Agencies, e.g., Child and Family Services |
|  |  |
|  | Private Practitioner, e.g., Chartered Psychologist, Psychiatrist, Therapists |
|  |  |
|  | Other School Systems |
|  |  |
|  | Other |

**I understand that the information is confidential and that the information is protected as outlined by the Freedom of Information Privacy and Protection Act.**

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Parent Signature |  | Date |
|  |  |  |
|  |  |  |
| Phone |  |  |