Thorson Therapy, LLC
Bryan Thorson, MSW, LCSW
1034 S. Brentwood Blvd.
Richmond Heights, MO 63117
Phone: 314-952-2426 Email: BryanThorson@me.com

Release of Information Request Form

Name of School: _____

Address: _____

City: _____State_____Zip Code_____

Phone:_____Fax:_____

I give permission for the release of information on:

Name of Student: Date of Birth:

I understand that the information is being obtained for educational purposes. Parent/ Guardian written release of school records to other public education institutions in which student seeks or intends to enroll in not required by law. This transfer is provided for in the Family Education Rights and Privacy Act as amended June 17, 1976. Parent/ Guardian written permission is required for release of school records to private or public institutions.

The documents to be released are described or listed as: Current Special Education Evaluation, Individualized Education Plan and verbal communication regarding academic and behavioral performance.

The records are required for the specific purpose of: Continuity of care

I understand that my authorization will remain effective from the date of my signature until
_____, and that the information will be handled confidentially in compliance with all applicable federal laws.

I understand that I may see the information that is to be sent, and that I may revoke the authorization at any time by written, dated communication. I have read and understand the nature of this release.

Singned: _____ Date: _____