



Chesterfield County Public Schools



Department of Equity and Student Support Services

School Phone Number:  
School Fax Number:

# Release of Information

Student Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Date: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Home Address: \_\_\_\_\_  
Student No.: \_\_\_\_\_

Age	Gender	Grade	School	Counselor
Parent/Guardian				
Name		Home Phone	Name	
Address		Work Phone	Address	
		Emergency Phone		
			Emergency Phone	

CCPS is requesting your consent to release information to and/or receive information regarding the above named student from the following agency or individual.

Name/Agency: \_\_\_\_\_ Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Name/Agency: \_\_\_\_\_ Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Name/Agency: \_\_\_\_\_ Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

I give permission for Chesterfield County Public Schools to release information to and/or receive information from the above agency or individual

My permission for this release is valid until:

Until the date of \_\_\_\_\_

One calendar year from the date of my signature

I notify CCPS staff I no longer give permission

I do not give permission for Chesterfield County Public Schools to release information to and/or receive information from the above agency or individual

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Signature Date

Please send information to:

School Name: \_\_\_\_\_ Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_