Deena Abbe, PhD
Children and Family Practice

Consent for Release/Exchange of Student Records and Information

Student's Name: ___________________________________ Date of Birth: _____/_____/_____

I hereby give permission to release/exchange copies of and/or share information contained within the Student's school student records listed below:

_____ **All School Student Records**, including but not limited to:
Cumulative-permanent record, special education records, grade reports, discipline records, health records, attendance records, test scores, copy of birth certificate, etc.

_____ **All Special Education Records**

_____ **Specific School Student Records** (checked below):

____Medical Information ___ Social Histories ___ Psychological Evaluations
___ Psychiatric Evaluations ___ IEP ___ Speech/Language Evaluations
___ Health/Attendance records ___ Birth Certificate ___ Physical Therapy Evaluations
___ Test Scores ___ Occupational Therapy Evaluations
___ Cumulative-Permanent Record ___ Copy of Physical for Athletics
___ Other: ____

_____ **Other** (Specify): ____

This information is to be released/exchanged between:

School/Agency: ______________________________ Deena Abbe, PhD

Address: ____________________________________ **AND** 356 Veterans Memorial Highway, Ste 6
Commack, NY 11725

Attn: ____ Attn: ___________________________________

____________________________ _____/_____/_____ ______________________________
Parent/Guardian Date

E-mail: dabbephd@gmail.com Telephone: 631-656-6055
Address: 356 Veterans Memorial Highway, Suite: 6,
Commack, New York 11725