



**AUTHORIZATION FOR RELEASE OF INFORMATION**

CHILD'S NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

I hereby give consent for the exchange of the information as checked below concerning the above name child between the party indicated and the A. Sophie Rogers School for Early Learning at the Schoenbaum Family Center. This release allows the School and School personnel to share information including, but not limited to, written and verbal communication.

\_\_\_\_\_ Release Information:

\_\_\_\_\_ Name

\_\_\_\_\_ Address

\_\_\_\_\_ City, State, Zip code

\_\_\_\_\_ Telephone

\_\_\_\_\_ Fax

\_\_\_\_\_ Release Information:

A. Sophie Rogers School for Early Learning

175 E. 7<sup>th</sup> Ave Columbus, OH 43201

Phone 614-247-7488 \*\* Fax 614-247-7360

\_\_\_\_\_ All personally identifiable data on file  
Tests/screening conducted  
Any other information for education purposes

This information to be used for: Educational Purposes

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

\_\_\_\_\_  
Date