**Authorization for Release of IEP from School System**

Patients Name: ____________________________________________

Date of Birth: ____/____/______

Name of School child attends: ____________________________________________________________

School System child attends: ____________________________________________________________

I __________________________________________________ hereby give my consent to
(Parent or Guardian's name)

_________________________________ to release _____________________________
(School system) (Patient's Name)

current IEP to Southern Therapy Solutions.

My child receives _______________________________ therapy in this school system. Information is needed regarding school related therapy for current school year __________ to __________.

Please fax current IEP to: 1-888-450-0379

Or mail to:

Southern Therapy Solutions
3256 North Valdosta Road
Valdosta, GA 31602

_____________________________________________ _____________________
Signature of Parent or Guardian Date

Initial: ___