

Lincoln Public Schools
1624 Lonsdale Avenue
Lincoln, RI 02865
(401) 721-3300

Student: _____ DOB: _____

Parent's Name: _____

Student Address: _____ Phone #: _____

School of Attendance: _____ Grade: _____

_____ and The Lincoln School Department is authorized to

obtain from or **release to:**

Attention: _____

Agency/School: _____

Street: _____

Apartment/Suite Number or P.O. Box: _____

City/Town: _____ State: _____ ZIP Code: _____

Phone: _____

_____ All of the following or specific evaluations

_____ Reciprocal Communication

_____ Neurological Evaluation

_____ Clinical Psychological Evaluation

_____ MDT/TQPP Report

_____ Educational Evaluation

_____ Medical History from Doctor

_____ Classroom Observation

_____ Psychiatric Evaluation

_____ Hearing and Vision Test/Screening

_____ Psychological Evaluation

_____ IEP

_____ Report Card/Transcript

_____ Immunization Record

_____ Social History

_____ Language Proficiency Test

_____ Therapy Evals. OT ___ PT ___ S/L ___ APE ___

_____ LD Documentation

_____ Teacher Questionnaire

_____ Other _____

Reason for Request: _____

Information released with this authorization will not be given, transferred, or in any way relayed to any other person(s) not specified above without additional authorization. This authorization expires _____ and may be withdrawn at any time.

Signature: _____ Date: _____

(Circle one: parent / guardian / educational advocate)