



Educational Advocacy Services

## Medical, Psychological and Educational Records Release

I hereby authorize \_\_\_\_\_  
(school) to release a copy of medical, psychological, and/or educational records, including IEPs, test protocols and other diagnostic information pertaining to \_\_\_\_\_, (DOB \_\_\_\_\_) of whom I am the parent/legal guardian to:

**Kathleen K. Edwards, Ed.D**  
**7807 Convoy Ct. #160**  
**San Diego, CA 92111**

I understand that Kathleen K. Edwards, Ed.D may not further use or disclose this information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

This authorization shall become effective immediately and shall remain in effect until one year from the date shown below.

I understand that I have a right to receive a copy of this authorization upon my request.

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Telephone: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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