



AUTHORISATION FOR RELEASE OF INFORMATION

PURPOSE: As a parent, guardian, or student, you have the right to give permission or not give permission for the release of information with other persons or agencies. This request provides you with the opportunity to approve or not approve such a request.

Students Name: _____ Date: _____

Date of Birth: _____ School: **Shekou International School**

I hereby authorize the release of records to the following (check any/all that apply):

- SIS Counsellor
- SIS Counselling and Learning Support
- SIS Counselling/Learning Support and Homeroom Teacher
- SIS Counselling/Learning Support and Specialist Teacher(s)

Describe the records to be disclosed:

The reason for disclosing the record(s) is:

Mutual exchange of information to assist the student academically and/or social-emotionally

I understand that the information obtained will be treated in a confidential manner by the school under the provisions of regulatory and professional practice and ethical standards that prohibit disclosure of personally identifiable information without consent.

I understand that my consent for the release of records is voluntary, and I can withdraw my consent at any time in writing. Should I withdraw my consent, it does not apply to information that has already been provided under the prior consent for release.

Parent/guardian/adult student

Signature

Date