This first page provides instructions only.

1) Write in your school or school district name rather than the teacher assigned to your student. This allows us to speak to any involved in the care of your child employed or contracted with the school district

Also, include all other current caregivers you wish us to collaborate with; many find it useful to include the students' private service providers.

When completed in this manner we revisit this document annually only.

- Check all boxes which may apply.Typically this includes those in bold font.
- 3) If you can participate then, place two marks here. One mark next to each arrow

If you are not participating, then write **NA** next to the first arrow and check the top box by the second arrow.

In 2024 Pinnacle Education opens a tutor training clinic in which we hope our students can participate as examples. This means a student's lesson may be recorded and a clip may be shared to help educate others in teaching methods. You are not required to participate and we are happy to honor your wishes as indicated on this form.

		Authoriz	ation for t	he Release or Ex	change of	Information	•
		when completed a	and signed b	by you, authorizes S nformation regarding	arah M. Fish,	to exchange	(obtain, release of
1)		hool District, Jane Sm		r, therapist, psychologist, occupat oulous Therapist	ional therapist, speech	h and language therap	ist other service providers)
	Name (stu	dent): Bob Jones		tains to specific clin	ical informat		j:
	Address:_	000 100th Street City,					
		ardian Name (if app	ilcable)	bert Jones			
	Phone of p	parent/guardian:00	00-000-0000				
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This document is valid only when a hand (or finger) signature has been used; it is not valid if you type in a signature. Ways to remotely complete this document include:

- digital signature using your iphone photo app (screenshot the PDF and *draw* the signature)
- print, wet-ink sign and send a cell photo of the signed paper
- digital signature app like DocUsign
- open as a PDF in another piece of software or app (Adobe, Kami, etc)

-----The following page is to be signed and returned prior to service commencement.-----

PinnacleEducationServices.com

Washington State

Authorization for the Release or Exchange of Information

This form, when completed and signed by you, authorizes <u>all agents of Pinnacle Education Services LLC</u>. to exchange (obtain, release or share) protected health and educational information regarding you/your child with the person or organization designated below.

Organization/Person school district, doctor, therapist, psychologist, occupational the Name all below that you would like us to consult with. All district personnel can be covered by naming	erapist, speech and language therapist other service providers, etc. the district rather than each person's name.
This Authorization pertains to specific clinical Name (student):DOR	
Parent/Guardian Name:	
Address of student:	
Phone of parent/guardian:	
I,, authorize all ag parent/guardian name to exchange (obtain, release or share) the following information: generally, just the bold font records	ents of Pinnacle Education Services LLC.
Educational Records	Psychiatric Evaluation Mental Status Exam ports Health Treatment Plan
OLIENTIQUA PRIANI CIONATURE	
CLIENT/GUARDIAN SIGNATURE:	DATE:
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