



Welcome to Sylvan!

Authorization to Exchange Information

To make sure we provide the most effective Sylvan experience possible for your student, please share the information below.

Student Name _____ **Customer Name** _____

I understand that during the course of tutoring by Sylvan Learning, it may become necessary for Sylvan to consult with educators, or other professionals such as physicians concerning my student. I expressly authorize and consent to a Sylvan consultation with such professionals and experts on my student's behalf. I understand that in the course of such consultation, Sylvan may receive or give information that is of a confidential nature.

I hereby authorize Sylvan to receive and give information that may be beneficial in the instruction of my student. I also authorize my student's educators, physicians, and others who may possess confidential information concerning my student to divulge and deliver that information to Sylvan. A facsimile of this authorization should be sufficient to authorize the delivery of such information to Sylvan. Should I, at any time, wish to retain the confidential nature of any such information, I will advise you in writing.

Please select one of the options below and sign at the bottom of the form:

- YES**, I have read the above and grant authorization as stated. (Please complete the information below.)
- NO**, I do not give permission for Sylvan to obtain or release information to any outside professional working with my student

School _____ **Phone** _____

Address _____ **Principal** _____

_____ **Counselor** _____

Teacher(s)	Subject(s)	Contact Details (email, phone/fax)

Is your child currently in any special placement in school? (reading, math, speech, EH, LD, etc.) If yes, please explain: _____

Customer Signature _____

Date _____