

**Aurora University  
Reading Clinic**

Institute for Collaboration, Room 225  
347 S. Gladstone Avenue  
Aurora, IL 60506  
Dr. Roberta Linder, Reading Clinic Director

RELEASE FORM

AUTHORIZATION FOR RELEASE AND/OR EXCHANGE OF INFORMATION

I hereby authorize the exchange / release of records pertaining to:

Pupil: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

BETWEEN:

Aurora University  
Reading Clinic  
347 S. Gladstone Avenue  
Aurora, IL 60506

AND: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

This may include written information such as:

- Test results (ISAT, AIMSWeb, DIBELS, etc.)
- Other school records indicating student performance
- Report completed by the Aurora University Reading Program tutor

This may also include verbal communication between the two parties listed above regarding my child, for example between the Reading Program tutors and the child's classroom teacher(s).

This information will be used in order to ensure that the assessment and tutoring address the needs of your son / daughter. In addition, this will allow Aurora University to share information with personnel at the home school.

Thank you.

Parent / Guardian signature \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Phone number(s) \_\_\_\_\_

Date \_\_\_\_\_