# SOARING SKILLS LLC

*Authorization to Exchange Records*

## PARTICIPANT INFORMATION

**PARENT/GUARDIAN FIRST NAME**

_____

**PARENT/GUARDIAN LAST NAME**

_____

**CHILD'S FULL NAME**

_____

**ADDRESS & PHONE NUMBER**

_____

## RECORDS TO BE EXCHANGED BETWEEN

**ORGANIZATION A**

**Soaring Skills LLC**

909 Williams St.
Viroqua, WI 54665
608-306-0859
soaring.skills.wisconsin@gmail.com

**Owners:**
Kasie Moran
Michael Elliot
Amanda Elliot

**ORGANIZATION B ( Authorized to Exchange Records With)**

**NAME OF SCHOOL / DISTRICT / CLINIC / PROVIDER**

_____

**ADDRESS**

_____

**PHONE NUMBER**

_____

**CONTACT NAME (if applicable)**

_____

## SCOPE OF RECORDS AUTHORIZED FOR EXCHANGE

***I authorize the organizations named above to exchange educational, developmental, behavioral, psychological, medical, and other records related to my child, including but not limited to the most recent IEP, IFSP, 504 Plan, evaluations, assessments, therapy records, and progress reports, as applicable.***

**RELEASE VALID FROM**

_____

**RELEASE VALID TO**

_____

## SIGNATURE

_____

*Parent/Guardian Signature*

_____

*Date*