AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Name of Student: _____ **Grade:** _____ **Date of Birth:** _____

***I hereby authorize*:**

School/Agency/Individual:	
Address:	
Address:	
City, State, Zip Code:	
Telephone:	**Email address:**
Fax:	**Website:**

***To release the information below regarding my child to*:**

School/Agency/Individual:	
Address:	
Address:	
City, State, Zip Code:	
Telephone:	**Email address:**
Fax:	**Website:**

Requested Items	Description	Items released by please initial
☐	Cumulative Student Records (Official transcript grades and tests scores)	_____
☐	Discipline Records and Attendance	_____
☐	Health Records & Certified Copy of Birth Certificate	_____
☐	Special Education Records (including speech therapy, IEP, Psychological report, Social Development Study, Multidisciplinary/Eligibility Conference Reports)	_____
☐	ISBE (Form IL Student)	
☐	Other _____	_____

I understand that I have the right to inspect and copy school records and to challenge the contents of these records. Federal and State Legislation requires that consent is needed for transfer of records beyond a third party. This authorization terminates one year from the date of permission.

_____ _____

Student Signature (if applicable) ***Date*** ***Parent/Guardian Signature*** ***Date***

_____

Parent/Guardian Printed Name

Parental permission is no longer required when records are requested by authorized school personnel (Family Educational Rights and Privacy Act, Final Rule on Educational Records, Federal Register, June 17, 1976, Vol. 41, No. 118, Page 24673).

Date requested, mailed, or faxed: _____ By: _____

Records received by and date: _____

Records distributed to: Counselor _____ Team/Teacher _____

Sped Ed (ESC) _____ Case Manager _____ Psychologist _____ Speech Path _____