AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

STUDENT NAME _____ DATE OF BIRTH_____

I hereby authorize the release of information to/from the agency and/or person listed below:

_____
NAME OF PERSON/AGENCY

_____ _____
STREET ADDRESS CITY, STATE, ZIP

_____ _____
PHONE NUMBER FAX NUMBER

_____
EMAIL ADDRESS

CHECK ALL APPROPRIATE:

- ☐ TRANSCRIPTS AND EDUCATIONAL RECORDS
- ☐ MEDICAL / HEALTH EVALUATIONS AND RECORDS (if applicable)
- ☐ ATTENDANCE AND DISCIPLINARY REPORTS
- ☐ PSYCHOLOGICAL AND COUNSELING RECORDS (if applicable)
- ☐ SPECIAL EDUCATION RECORDS / IEP REPORT (if applicable)
- ☐ OTHER (SPECIFY)_____

I understand that this information obtained will be treated in a confidential manner by the school district under the provisions of the family education rights and privacy act (FERPA). FERPA prohibits disclosure of personally identifiable information without consent except in limited circumstances. Please note that if the request is for health or medical information, the medical information received by the district is protected under FERPA privacy standards and not the health insurance portability and accountability act (HIPAA).

I understand that my consent for the release of records is voluntary and I can withdraw my consent at any time in writing. Should I withdraw my consent, it does not apply to information that has already been provided under the prior consent for release.

_____ _____
PARENT, GUARDIAN, ADULT STUDENT SIGNATURE DATE