

## Permission to Obtain & Release Information

Dear Parent:

In order to obtain and release information regarding your child, \_\_\_\_\_, please complete and return this form. If you have any questions, my contact information is provided below.

<b>Name &amp; Title of Contact Person</b>	<b>Address</b>
<b>Phone</b>	<b>Email</b>

I, the undersigned, hereby request and authorize:	
School District or Public Agency:	
Address:	
School District or Public Agency Contact Person:	

To release to or obtain from:	
Agency:	
Address:	
Agency Contact Person:	

Information Provided for:	
Name of Child:	Date of Birth:

Information Requested:
<input type="checkbox"/> Official child academic/administrative records (identifying information, grade level completed, grades, class rank, attendance records, and group aptitude and achievement assessment results)
<input checked="" type="checkbox"/> Medical and/or related health records, including:
<input type="checkbox"/> Special Education confidential file (Evaluation, Eligibility & IEPs)
<input type="checkbox"/> Participation, development or implementation of the IEP and exchange of applicable agency documents.
<input type="checkbox"/> Other (specify):

Purpose of Disclosure

**\* This permission is valid for one year from the date signed. A copy of this form is as effective as the original.**

*I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent and that the written revocation must be given to the agency/organization I authorized to release information. I recognize that health records, once received by the school district or public agency, may not be protected by the HIPPA Privacy Act and may become education records protected by the Family Educational Rights and Privacy Act (FERPA). I also understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain health care.*

Signature	Relationship	Date