MARSEILLES elementary

Brenda Donahue
MES 150 Superintendent
bdonahue@mes150.org

Shawn Collins
MES 150 Principal
scollins@mes150.org

201 Chicago St., Marseilles, IL 61341 815.554.4338

Please email records to register@mes150.org | SPED records should be emailed to cpellino@mes150.org

Authorization for Release of School Student Records

Name of Student:		Birth Date:
Address:	City/State:	Zip:

I, _____, am the parent/guardian of the above named student, and I hereby grant permission to Marseilles Elementary School District 150 to release confidential school student records concerning my child.

Receiving District, Individual, or Agency:_____
Reason for records transfer:

☐ Transferred ☐ Medical ☐ Other:_____

☐ I authorize Marseilles Elementary School District 150 and the school district, individual, or agency below to mutually exchange student record information, including via conversation, about my child.

I understand that I have the right to inspect, copy, and/or challenge the contents of the school student records for which I am authorizing release. I further understand that I may limit this authorization to the specific school student records or portions of school student records as designated below.

Records to be Released (Mark All That Apply)

☐ All Student Records

By Category:

☐ Name
☐ Date of Birth
☐ Grade Level
☐ Grades/Transcripts
☐ Attendance/Class Schedule
☐ Other:_____

☐ Medical Records
☐ Mental Health Records
☐ Disciplinary Information
☐ Sped/IEP/504 Records
☐ Test Scores/Reports

☐ Parents' Names/Addresses
☐ Family Background Information
☐ Extracurricular Activities
☐ ISBE Form 33-78

This authorization is valid until _____ unless otherwise revoked in writing. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I understand that my revocation of this authorization will not be effective for action, taken by the school district or the designated individual/agency in reliance upon my authorization and prior to notice of my revocation. I understand that failing to authorize disclosure of records may adversely impact the education programming for my child. I recognize that health records, once received by the school district, may not be protected by the HIPAA Privacy Rule, but will become education records protected by the *Family Education Rights and Privacy Act* and the *Illinois School Student Records Act.* I also understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain a free education.

_____
Parent/Guardian Signature Date

_____
Student Signature (If student is over 12 years of age and the authorization is for the release of mental health records) Date

_____
Witness Signature Date