Adlai E. Stevenson High School • One Stevenson Drive • Lincolnshire, Illinois 60069
847-415-4000

AUTHORIZATION FOR RELEASE/EXCHANGE OF INFORMATION

Name of Student: ____

Birth Date: ____________________ Date of this Request: ____________________

I/we, the undersigned, hereby authorize and consent to the release/exchange of the following student record information regarding the student to/with the person/agency specified below:

- ☐ All Permanent Records
- ☐ All Temporary Records
- ☐ Official Transcript
- ☐ Report Cards/Progress Reports
- ☐ Group-Administered Standardized Tests (e.g., PLAN, EXPLORE, PSAE, ACT, SAT, etc.)
- ☐ Attendance Records
- ☐ Discipline Records
- ☐ Health Records and Health-Related Information
- ☐ All Special Education/Section 504 Records
- ☐ Section 504 Plans/Individualized Education Plans (IEPs)
- ☐ All Case Study Evaluation Reports
- ☐ Psychological Evaluations
- ☐ Educational Evaluations
- ☐ Behavior Rating Scales/Functional Behavioral Assessments
- ☐ Adaptive Functioning Assessments
- ☐ Transition Assessments
- ☐ Speech/Language Evaluations
- ☐ Occupational and/or Physical Therapy Evaluations
- ☐ Private Counseling/Therapy Records
- ☐ Other (Specify): ____________________
  ____
  ____

Name, address and other contact information of person/agency to/with whom student records will be released/exchanged:

____

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These disclosures are authorized pursuant to 20 U.S.C. Section 1232g, 105 ILCS 10/1 et seq., and 740 ILCS 110/1 et seq., and are to be made for the purpose of educational planning, coordination of services, and/or ______ ____________________. I/we understand that I/we have the right to inspect and copy the records and information to be disclosed, challenge their contents, and limit my/our consent to designated records or portions of the information or communications contained in those records. I/we also understand that my/our refusal to consent to the exchange of records & communications could result in incomplete educational planning.

This consent expires one year from the date indicated below. However, I/we understand that I/we have the right to revoke this consent in writing at any time.

______________________________ ____________________
Parent/Guardian Signature (Date)

______________________________ ____________________
Student Signature (required for all students to whom records rights have transferred and, for students age 12 and older, for disclosure of mental health or developmental disability records) (Date)

______________________________ ____________________
Witness Signature (required for mental health/ developmental disability records only) (Date)

cc: Student Temporary File
09/12