AUTHORIZATION FOR RELEASE/EXCHANGE OF INFORMATION

Lemont High School • 800 Porter Street • Lemont, IL 60439 • (630) 257-5838 • www.lhs210.net

I hereby authorize the exchange of communications and the release/exchange of the following records concerning

_____ between the agents and employees of **Lemont High School District 210** and:
(Student's name)

Name/Title: _____

Agency/Organization/Previous School: _____

Address: _____
(Street) **(City)** **(State)** **(Zip)**

Phone ( ) _____ **E-Mail Address:** _____

I hereby authorize that the following information will be released/exchanged *(please check all that apply):*

____ **All Permanent Records** (including, but not limited to: basic identifying information; birth certificate or other proof of student's identity; official academic transcript; attendance records; health records; and, where applicable, scores received on all state assessments administered in grades 9-12, including designation of student's achievement of the State Seal of Biliteracy or State Commendation Toward Biliteracy)

____ **All Temporary Records** (including, but not limited to: scores on state assessments administered in grades K-8; discipline records; health-related information; accident reports; family background information; psychological evaluation reports; aptitude and achievement test results; report cards; honors and awards; progress monitoring information; IDEA/special education records; and Section 504 records)

____ **Other** *(please specify)*: _____

These disclosures are authorized pursuant to the *Family Education Rights and Privacy Act* (20 U.S.C. Section 1232g), the *Illinois School Student Records Act* (105 ILCS 10/1 et seq.), and the *Illinois Mental Health and Developmental Disability Confidentiality Act (740 ILCS 110/1 et seq.) and are to be made for the purpose of:**

____ **Educational evaluation and/or planning**

____ **Other** *(please specify)*: _____

** Prior to the release of protected health information, health care providers may require the parent/guardian to execute an additional authorization form to comply with the Health Insurance Portability and Accountability Act (HIPAA).*

Please send records to the attention of:

____ **Dr. Christine Flores, Director of Special Education Services (cflores@lhs210.net)**

____ **Heather Richa, Registrar/Counseling Secretary (hricha@lhs210.net)**

I understand I have the right to inspect and copy the information to be disclosed, challenge its contents, and limit my consent to designated records or portions of the information contained in those records. I also understand my refusal to consent to the exchange of records and communications could result in incomplete and/or inappropriate educational planning for the student. This consent expires one year from the date indicated below. I understand I have the right to revoke this consent in writing at any time.

PARENT/GUARDIAN NAME *(printed)*: _____

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** ____/____ / ____

WITNESS SIGNATURE: _____ **DATE:** ____/____ / ____
(required for mental health/developmental disability records)

STUDENT SIGNATURE: _____ **DATE:** ____/____ / ____
(required for mental health/developmental disability records, if student is age 12 or older)