ADLAI E. STEVENSON HIGH SCHOOL
DISTRICT 125

AUTHORIZATION FOR RELEASE/EXCHANGE OF INFORMATION

(ALSO FOR USE AND DISCLOSURE OF PROTECTED HEALTH AND EDUCATIONAL INFORMATION UNDER HIPAA AND THE MHDDCA)

Student		**Date of Birth**	
Address **City, State, Zip**		**Phone**	

I/We hereby authorize the exchange of communications and the release/exchange of the following records concerning the aforementioned student between the Adlai E. Stevenson High School and the person/school/agency specified below:

Name of School, Person or Agency	
Address **City, State, Zip**	
Phone Number AND Fax Number	

I/we hereby authorize that the following information will be released/exchanged:

☐ **All permanent records:** Including but not limited to basic identifying information, birth certificate or other proof of student's identity, academic transcripts, attendance records, health records, and where applicable, scores received on all State Assessments administered in grades 9-12 and designation 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, reports cards, progress reports, honor and awards, progress monitoring information, IDEA/Special Education records, IEP and section 504 Records, Case Study Evaluations, Behavioral Assessments, Educational/Therapy Evaluation

☐ **Others (specify)**: _____
_____

These disclosures are authorized pursuant to the Family Educational Rights and Privacy Act (20 U.S.C. Section 1232g), the Illinois School Student Record 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 (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: Check all that apply List name/ phone number of specific people if applicable	**Adlai E. Stevenson High School** **1 Stevenson Drive** **Lincolnshire, IL 60069** **or**	☐ **Counselor Only** **Name/Phone:** _____ ☐ **Social Worker Only** **Name/Phone:** _____ ☐ **SST Team** ☐ **Special Education** **Name/Phone:** _____ ☐ **Nurse** ☐ **Other:** **Name/Phone:** _____

I understand that 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 that 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 on year from the date of signature. However, I understand that I have the right to revoke this consent in writing at any time.

_____ _____ _____
Parent/Guardian Printed Name | Parent/Guardian Signature | Date

_____ _____ _____
Student Printed Name | Student Signature | Date

_____ _____ _____
Witness Printed name | Witness Signature | Date
(Required for mental health/developmental disability records only)