School City of East Chicago
Special Education Services

1401 East 144th Street, East Chicago, IN 46312
Ph: 219.391.4100 Fax: 219.391.4146

Release of Information

Information Requested:

- ☐ **NO** records and information may be released (parent/guardian's initial refusal)
- ☐ **ALL** Records and information may be released
- ☐ Release only the Following records:
  - ☐ Educational records: student transcripts- grades, attendance, behavioral history
  - ☐ Student academic testing results
  - ☐ Student Special Education records (teacher reports, IEP, ITP)
  - ☐ Student medical Records
  - ☐ Student social/emotional data (psychiatric, counselor, social work)
  - ☐ Student mental health diagnosis
    - ☐ Clinical assessment
    - ☐ Treatment plan
    - ☐ Progress notes
    - ☐ Discharge summary
    - ☐ Medication
- ☐ Other (explain): ____________________

Records will be released through ____________ or one (1) calendar year from date of signature, or until said Parent/Guardian/Surrogate Parent rescinds this release in writing.
It is understood that this consent to release information will assist SCEC in implementing an appropriate educational program and support services for my child. I hereby give my consent for an exchange of information to the extent specified above among designated parties. All reports will be stored and disseminated in accordance with section #513 of subsection PL 93-380 (Family Rights and Privacy Act of 1974) and subsequent amendments.

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Name of School, Agency, or Doctor

____

Address

____

City, State, Zip

____

Name of Student Date of Birth

Return to:
Name of Staff Person
School
Address
Fax No.

Parent or Guardian Signature

Parent or Guardian Name (Print)

Address

City, State, Zip

Telephone

Date

A copy of this signed Release must be sent to Special Education Services.