AUTHORIZATION FOR RELEASE/EXCHANGE OF INFORMATION

I, _____ hereby authorize the exchange of communications
(Print name of parent/guardian/student if 18 or greater)

and the release/exchange of the following records or confidential information and/or communications

concerning _____ (hereinafter "the Student") between Hinsdale Township

High School District 86 its agents and employees and

_____:
(Print name of person / agency)

_____	Psychological Evaluation	_____	Psychiatric / Medical Reports
_____	Social Developmental Study	_____	Individualized Education Plans
_____	Speech and Language Evaluation	_____	Progress Reports
_____	Health History	Other: _____	

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 following purpose(s):

_____.
(Print purpose(s))

I understand that I have the right to inspect and copy the records and information to be disclosed, challenge their contents, and limit my consent to designated records or portions of the information or communications contained in those records. I also understand that my refusal to consent to the exchange of records and communications could result in a delay of educational services.

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

_____ _____
PARENT/GUARDIAN SIGNATURE (if Student is less than 18 years and/or Delegation of Rights has been obtained) — DATE

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

_____ _____
WITNESS SIGNATURE (for mental health/ developmental disability records) — DATE

* NOTE: 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").
7/2017

7.15.19