Columbus School District
Permission to Exchange Information

Dear _____ Date_____

In order for us to obtain and release information regarding your child, we must have your permission. Please complete this form where indicated, including your signature and date. If you have questions, please contact me at (920)623-5950.

_____
Name and Title of School Contact

_____
Name of School

I, the undersigned, hereby request and authorize:

Relative	Relation(s) to the student
Address	City, State, Zip
Phone	Email

To obtain and release information as indicated below for:

Name of Child	Date of Birth

☐ Official student cumulative and progress records (includes identifying information, grade level, grades, courses taken, class rank, attendance, group test results)

☐ School Behavioral records (includes Individualized Education program (IEP), results of individual testing, special education, at-risk or English Language Learner status, Physical Health Records, behavioral and/or academic interventions)

☐ Specific Medical and/or related health records as follows: _____

☐ Specific Psychological, Psychiatric and/or Social Work reports as follows:_____

_____

☐ Appropriate agency reports

☐ Other: Specify_____

I understand that this information will be kept confidential and will be used in the best interest of my child. I understand that I have the right to refuse this request. This release is valid for the current school year(July 1st through June 30th), unless revoked in writing.

Signature: (Please circle one)	Parent	Guardian	Adult Student	Date
Signature: (Please circle one)	Parent	Guardian	Adult Student	Date