Date Sent: ________________ ☐ Faxed ☐ Emailed ☐ Mailed Sent By: ____________________

AUTHORIZATION TO RELEASE CONFIDENTIAL RECORDS

This document is a reciprocal release of information form

To: Records Request Office
Records Custodian

Cherokee County School District
School/Agency

P.O. Box 769 Canton, GA 30169
Address City/State/Zip

sped.records@cherokeek12.net
Email

PH 770.721.8506 Fax 770.721.6316
Phone/Fax

From: ____________________
Person Requesting Records

____
School/Agency

____
Address

____
City/State/Zip

____
Phone/Fax/Email

YOU ARE HEREBY AUTHORIZED AND INSTRUCTED TO RELEASE CONFIDENTIAL INFORMATION REGARDING:

____
First Middle Last

____________________ ____________________
Date of Birth Grade Level / School

REASON FOR REQUEST (OPTIONAL):

Educational Evaluation and Program Planning
Maintenance of Student Records
Other: ____________________
Medical Problems Related to Learning
Medical Evaluation and Treatment
* For IEP only - Date of upcoming IEP meeting

PLEASE SPECIFY THE RECORDS TO BE RELEASED:

Psychological Report
Educational Evaluation
Social History
I.E.P. (Minutes & Goals/Obj.)
Hearing / Vision Screening Results
Medical Exam Report Form
Psychiatric Evaluation
Eligibility Report
Anecdotal Records
Medical Records
Other: ____________________

Authorization:

This authorization is valid for one year or as specified:________________________ **It will expire on:**______________

I hereby represent that I lawfully possess the parental authority (*as parent, guardian or adult student*) to authorize the release of the records specified above, and I agree to allow representatives of the school system to check my driver's license or government issued photo identification in order to verify my identity. (*If this request is delivered other than in person, I understand that my signature must be notarized*) I understand that the Cherokee County School District will rely upon this representation in considering this request for records. I understand that providing consent to release records is voluntary on my part. The Cherokee County School District may impose nominal fees for copying in certain circumstances. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I recognize that health records, once received by the local education agency (LEA), may no longer be protected by HIPAA, but they will become education records protected by the Family Educational Rights and Privacy Act (FERPA).

____________________ ____________________
Parent/Guardian/Adult Student Printed Name Relationship to Student

____________________ ____________________
Parent/Guardian/Adult Student Signature Date

Please submit a photo copy of your state issued identification and this completed/notarized form to initiate your request.

(Required if ID Not Verified) by CCSD. Sworn to and subscribed before me this

________ day of ____________________, 20______

____

Notary Public

My Commission Expires: ____________________