AUTHORIZATION FOR RELEASE OF RECORDS

Purpose: As a parent, guardian or student, you have the right to give permission or not give permission for the release of your child's records with other persons or agencies. This request provides you with the opportunity to approve or not approve such a request unless release of records is allowed under one of the exceptions under the rules implementing the Family Education Rights and Privacy Act, FERPA, (for example, transfer of records from one school district to another).

Student Name: _____ Student DOB: _____

School District: _____ Date: _____

I hereby authorize the release of records between:

_____ and _____

Name of Agency/Person — Name of Agency/Person

_____ _____

Street Address — Street Address

_____ _____ _____ _____ _____ _____

City State Zip Code — City State Zip Code

_____ _____

Phone — Phone

_____ _____

FAX — FAX

Describe the records to be disclosed:

The reason for disclosing the record(s) is:

I understand that this information obtained will be treated in a confidential manner by the school district under the provisions of the Family Education Rights and Privacy Act (FERPA). FERPA prohibits disclosure of personally identifiable information without consent except in limited circumstances. Please note that if the request is for health or medical information, the medical information received by the district is protected under FERPA privacy standards by a school district and not the Health Insurance Portability and Accountability Act (HIPAA).

This authorization is valid from _____ to _____

Note: For release of medical records, the authorization can be no longer than 90 days after this authorization is signed.

I understand that my consent for the release of records is voluntary and I can withdraw my consent at any time in writing. Should I withdraw my consent, it does not apply to information that has already been provided under the prior consent for release.

_____ _____

Parent/guardian or Student Signature — Date