



SAN ELIZARIO INDEPENDENT SCHOOL DISTRICT

Soaring to Excellence

PERMISSION TO RELEASE/REQUEST RECORDS

I, _____, authorize _____, ID#: _____ (Date of

to release records concerning my child, (Student's Name) _____
Birth) School _____ Grade _____

FROM: Name: _____
(Position) _____
San Elizario Independent School District

TO: Name: _____
Address _____

City: _____ State: _____ Zip: _____

Records to be released:

- Psychological/Psychosocial Evaluation Report
- Medical information
- Educational Assessment Reports
- Socioeconomic information
- §504 committee deliberation and decisions
- Vocational assessment reports
- § 504 eligibility forms
- Immunizations
- Other: _____

Purpose for disclosure: Determine appropriate educational program
 Other: _____

Yes No I understand that the purpose of this release/request is to allow the San Elizario Independent School District to obtain confidential information which will be useful in arriving at decisions for educational programming and placement for my child.

Yes No I have been fully informed and do understand the school's release/request for my consent, as described above. This information will be released/requested upon receipt of my written consent.

Yes No This authorization is effective for school year _____. I understand that my consent is voluntary and may be revoked anytime.

Signature of Parent, Guardian, Surrogate Parent, or Adult Student Date

Signature of Interpreter (IF USED) Date

Please return this form to _____ at _____ as soon as possible.
School staff person School