AUTHORIZATION FOR RELEASE OF INFORMATION
Mississinewa Community Schools
424 E. South A Street
Gas City, IN 46933

Student:	Parent/Guardian:
DOB: Gender: F M	Address:
School: Grade:	
Home phone:	Work Phone:

As legal parent or guardian of the above named student, I authorize:

Mississinewa Special Services Department Phone: 765-677-4426 Fax: 765-677-4458	**TO RELEASE INFORMATION TO:** **OR** **TO OBTAIN INFORMATION FROM:**	_____ (Agency or Person) _____ _____ (Phone and Address)

Information I authorize to be released: (Check the boxes that are appropriate)

O School Records	O Teacher, Counselor, or staff observations
O IEP and Psycho-education Evaluation	O Social Worker Reports
O Medical Records/Diagnosis Information Dr Visit Notes/Plan of Care/Progress Notes Psychiatric Reports/Treatment Records	O Chemical Abuse Dependency Reports

Purpose of Release:

- I have read information that I have access to and may review any or all of my child's school records. I understand that if I so desire, I may challenge the content of the records provided by the Family Educational Rights and Privacy Act (FERPA) of 1374
- This authorization begins the date that I signed it and is good for one calendar year. I understand that I have the right to revoke this authorization at any time. In order to revoke this authorization, I must do so in writing and present my written revocation to the above named authorized entity.
- I understand that the information disclosed may be shared with a multidisciplinary team.
- This release does not condition eligibility for benefits.

_____ _____

(Parent Signature) (Date)