



**MOUNT VERNON CITY SCHOOL DISTRICT**  
**Office of Pupil Personnel Services**  
**Mount Vernon, New York 10550**  
**Phone: (914) 358-2380 Fax: (914) 665-5170**

**FAMILY EDUCATIONAL RIGHTS AND PRIVACY ACT**  
**STUDENT RECORDS RELEASE FORM**

Student Name: \_\_\_\_\_ Student DOB: \_\_\_\_\_

Student Authorization for Disclosure

Family Educational Rights and Privacy Act (FERPA) is a federal law which sets forth requirements regarding the privacy of student records. For complete information regarding FERPA, please visit <https://www2.ed.gov/policy/gen/guid/fpco/ferpa/index.html> You may also request a copy of the relevant regulations from the District.

Authorized Consent for Release of Records

I understand that under the provisions of the Family Educational Rights and Privacy Act (FERPA) of 1974, as amended, these records will not be released to a third party without my approval. I hereby authorize Mount Vernon City School District to discuss and/or disclose the below identified educational records for the above student to the following individual(s):

Name of Authorized Person(s) to whom records may be disclosed and / or discussed: _____			
Relationship to Student: _____			
Address: _____		City: _____	State: _____ ZIP: _____
The purpose of this disclosure is: _____			
The records which may be disclosed and/ or discussed include: _____			
_____			

Please check all that apply:

<input type="checkbox"/>	Complete Transcript	<input type="checkbox"/>	Current Grades	<input type="checkbox"/>	Achievement Test Scores
<input type="checkbox"/>	NYS Assessment Scores	<input type="checkbox"/>	Individualized Education Program (IEP)	<input type="checkbox"/>	Social History
<input type="checkbox"/>	Psychological Evaluation	<input type="checkbox"/>	Educational Evaluation	<input type="checkbox"/>	Speech-Language Evaluation
<input type="checkbox"/>	Medical Evaluation	<input type="checkbox"/>	Neurological Evaluation	<input type="checkbox"/>	Psychiatric Evaluation
<input type="checkbox"/>	Immunization Records	<input type="checkbox"/>	Other: _____		

If documents are disclosed to the above identified person(s), I hereby request a copy of said records be provided to me (Circle One): Yes                      No

I have carefully read the foregoing authorization and fully understand the meaning and intent of this document. I understand the foregoing release shall remain in effect until withdrawn by me in writing. I affirm that I have signed this authorization voluntarily.

Parent Name (Print): \_\_\_\_\_

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_