DATE SENT/MAILED
_____

GALENA PARK SCHOOL DISTRICT

☐ RELEASE INFORMATION
X REQUEST INFORMATION

CONSENT TO REQUEST CONFIDENTIAL INFORMATION

Student's Name	Grade	DOB	Student ID
_____.	_____.	_____.	_____.

We are asking that you authorize the person or agency named below to release/to request specified records containing confidential information regarding the above named student.

_____ _____.
*NAME AND POSITION OF SCHOOL STAFF PERSON * NAME OF DOCTOR OR HOSPITAL REQUEST IS MADE

ADDRESS: _____
Dr's Phone # & Fax #

*RECORDS TO BE RELEASED/RECORDS REQUESTED	*PURPOSE OF DISCLOSURE
_____.Current ARD/IEP Documents _____.Assessment reports _____.Eligibility reports __√__.Other _____.	To assist with placement and programming decisions.

Please check (X) the appropriate boxes below. For more information please call:

_____ **at:** _____
SCHOOL STAFF PERSON TELEPHONE NUMBER

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

☐ Yes ☐ No *I understand that my consent is voluntary and may be revoked anytime.

☐ Yes ☐ No *The information provided to me has been provided in my native language or other mode of communication. If other than English, specify _____.

*Your rights were explained to you when you were/your child was initially referred for medical assessment / special education assessment. Federal regulations require that parents and adult students be provided a full explanation of all procedural safeguards (rights) in their native language or other mode of communication each time the district proposes of refuses to initiate or change the identification, evaluation, or educational placement of you or your child of the provision of a free appropriate public education (FAPE) to you or your child.

_____. _____.
*SIGNATURE OF PARENT / GUARDIAN DATE

Please return this form to: _____ at _____ as soon as possible.
SCHOOL STAFF PERSON SCHOOL

RETURN TO: