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Please email records to register@mes150.org | SPED records should be emailed to cruder@mes150.org

**Authorization for Release of School Student Records**

|                  |             |             |
|------------------|-------------|-------------|
| Name of Student: |             | Birth Date: |
| Address:         | City/State: | Zip:        |

I, \_\_\_\_\_, am the parent/guardian of the above named student, and I hereby grant permission to Marseilles Elementary School District 150 to release confidential school student records concerning my child.

Receiving District, Individual, or Agency: \_\_\_\_\_

Reason for records transfer:

Transferred     Medical     Other: \_\_\_\_\_

I authorize Marseilles Elementary School District 150 and the school district, individual, or agency below to mutually exchange student record information, including via conversation, about my child.

I understand that I have the right to inspect, copy, and/or challenge the contents of the school student records for which I am authorizing release. I further understand that I may limit this authorization to the specific school student records or portions of school student records as designated below.

Records to be Released (Mark All That Apply)

All Student Records

By Category:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Name                      | <input type="checkbox"/> Medical Records          | <input type="checkbox"/> Parents' Names/Addresses      |
| <input type="checkbox"/> Date of Birth             | <input type="checkbox"/> Mental Health Records    | <input type="checkbox"/> Family Background Information |
| <input type="checkbox"/> Grade Level               | <input type="checkbox"/> Disciplinary Information | <input type="checkbox"/> Extracurricular Activities    |
| <input type="checkbox"/> Grades/Transcripts        | <input type="checkbox"/> Sped/IEP/504 Records     | <input type="checkbox"/> ISBE Form 33-78               |
| <input type="checkbox"/> Attendance/Class Schedule | <input type="checkbox"/> Test Scores/Reports      |  |
| <input type="checkbox"/> Other: _____              |   |  |

This authorization is valid until \_\_\_\_\_ unless otherwise revoked in writing. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I understand that my revocation of this authorization will not be effective for action, taken by the school district or the designated individual/agency in reliance upon my authorization and prior to notice of my revocation. I understand that failing to authorize disclosure of records may adversely impact the education programming for my child. I recognize that health records, once received by the school district, may not be protected by the HIPAA Privacy Rule, but will become education records protected by the *Family Education Rights and Privacy Act* and the *Illinois School Student Records Act*. I also understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain a free education.

\_\_\_\_\_  
Parent/Guardian Signature Date

\_\_\_\_\_  
Student Signature (If student is over 12 years of age and the authorization is for the release of mental health records) Date

\_\_\_\_\_  
Witness Signature Date