



Fort Wayne Community Schools
Department of Special Education
1200 South Clinton Street Fort Wayne, IN 46802
Phone: (260) 467-1110 • Fax: (260) 467-1189

Informed Consent and Authorization for Release/Exchange of Information

Student Name: _____ Date of Birth: _____

School of Attendance: _____ Student Number: _____

I authorize release/exchange of information between Fort Wayne Community Schools, Department of Special Education, and:

Other Individual/Agency (see below)

Name/Position/Agency _____

Address _____

Phone Number _____

College(s)/University(s)/Scholarship(s)

Information to be released/exchanged verbally or in writing:

1. Transcript
2. Progress Reports
3. Behavioral/Disciplinary Records
4. Health/Psychological Records
5. Special Education Records
6. Other _____

Expiration: I understand that this consent can be withdrawn by me, in writing, at any time except to the extent that action has already been taken on the same. This consent will expire in twelve (12) months from the date signed. If desired, specify another expiration date, condition, or time period here: _____. I hereby consent to and authorize the release of information as described on this form. I have given this consent voluntarily and I understand that authorizing this disclosure is not required. I have been informed that I have a right to receive a copy of the above records if I so desire, and under certain circumstances, may request a hearing to challenge the content of same.

Signature: _____ Date: _____

Parent/Guardian/Student (if over 18)/Surrogate Parent

Typed or Printed Name