

Legal Name of Student _____	DOB _____	State Student ID (SASID) _____	Date _____
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REQUEST TO RELEASE OR SECURE CONFIDENTIAL INFORMATION
(Not required for release to another Administrative Unit)

This permission shall be valid for the following duration. Beginning _____ and shall terminate _____

Indicate Consent	Records/information to be released or secured:	Indicate Consent	Records/information to be released or secured:
☐ Yes ☐ No	☐ Audiometric	☐ Yes ☐ No	☐ Psychological
☐ Yes ☐ No	☐ Educational	☐ Yes ☐ No	☐ Physical Therapy
☐ Yes ☐ No	☐ IEP	☐ Yes ☐ No	☐ Social Work
☐ Yes ☐ No	☐ Medical	☐ Yes ☐ No	☐ Speech/Language
☐ Yes ☐ No	☐ Occupational Therapy	☐ Yes ☐ No	☐ Other: _____
☐ Yes ☐ No	☐ Psychiatric	☐ Yes ☐ No	☐ Other: _____

Purpose for the Disclosure

The purpose of the requested disclosure is as follows:

	From	To
Agency	_____	_____
Address	_____	_____
City, State, Zip	_____	_____

All information released or secured will be in compliance with the Family Education Rights and Privacy Act and the Colorado Open Records Law. No additional information will be released or secured without prior approval from the parent, except as provided by law.

PARENTAL CONSENT

I understand that consent is voluntary and may be revoked at any time in writing. I hereby authorize the transfer of information as indicated above.

Signature (Parent/Guardian/ESP) _____	Date _____
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☐ Date consent received by District/Administrative Unit: _____