

DISTRICT 155 CENTER FOR EDUCATION

One South Virginia Road Crystal Lake, IL 60014 **PHONE:** 815.455.8500 **FAX:** 815.459.5022

www.d155.org

Consent for Communication and Disclosure of School Student Records and Information Including Mental Health and Developmental Disability Information

Student's Name:		Date of Birth:	_
administrators, er		nool District No. 155 ("District") and its icate with and disclose records and an tified recipient:	y and all
Recipient Address: Phone: Email:			
Information to be	disclosed to/from recipient:		
including		nt information for the above-named stu created by the District pursuant to the left seq.	
may be d		nation from a therapist, doctor, or hosp ler the <i>Illinois Mental Health and Deve</i> 0/1 <i>et. seq</i> .	
The purpose for t	his disclosure is for:		
pursuant to this c not suffer any oth	onsent. If I do not grant this conse	challenge the information to be disclose ent, these records will not be released, valid for one calendar year from the d ng.	but I will
Parent/Guardian Signature Date		Witness Signature	
Student Signatu	re Date	Witness Signature	

Note: If only records and information pursuant to ISSRA are being exchanged, only the signature of the parent/guardian is required. If mental health records and information pursuant to the MHDDCA are being exchanged, only the parent's/guardian's signature is needed if the student is under age 12. If the student is between ages 12 and 18, both the parent's/guardian's and student's signature are needed. If the student is age 18 or over, only the student's (or if the student has been judged to be incapacitated by a court, the guardian's) signature is required.