



540 Superior Avenue
Calumet City, IL 60409

P: (708) 862-7665

F: (708) 868-7555

Dr. Joseph H. Zotto, Superintendent
Tara T. Lawrence, Assistant Superintendent

Authorization for Release of School Student Records

Name of Student:	Birth Date:
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Address:	City:	Zip:
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I/We, _____, am/are the parent(s)/guardian(s) of the above-named student, and I hereby grant permission to _____ release and exchange confidential school student records and information concerning my child to: _____

The purpose of this authorization is based on a request to release student records information for _____.

I authorize the District and the Agency/Individual listed above to mutually exchange student record information, including via conversations, about my student.

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 (or those records designated below)

By Category:

- | | | |
|--|---|---|
| <input type="checkbox"/> Name | <input type="checkbox"/> Date of Birth | <input type="checkbox"/> Address |
| <input type="checkbox"/> Grades/Transcripts | <input type="checkbox"/> Grade Level | <input type="checkbox"/> Parents' Names/Addresses |
| <input type="checkbox"/> Honors/Awards | <input type="checkbox"/> Honors/Awards | <input type="checkbox"/> Extracurricular Activities |
| <input type="checkbox"/> Attendance Records | <input type="checkbox"/> Health Records | <input type="checkbox"/> Mental Health Records |
| <input type="checkbox"/> Class Schedule | <input type="checkbox"/> Test Scores/Reports | <input type="checkbox"/> Disciplinary Information |
| <input type="checkbox"/> Family Background Information | <input type="checkbox"/> Special Education/504 Plan Records | <input type="checkbox"/> Medical Records |
| <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 actions 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 educational programming for my child. I recognize that health records,



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once received by the school district, may not be protected by the HIPAA Privacy Rule, but will become education records protected by the *Family Educational 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 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