



AUTHORIZATION FOR RELEASE OF INFORMATION

Full Student Name:

Complete Student Address:

Date of Birth:

Phone Number:

☐ To	☐ From
New Trier Township High School	
Phone: 847.446.7000 Fax: 847.835.9851	

☐ To	☐ From
Name:	
School/Organization Address:	
Email:	
Phone:	Fax:

Records and information to be released:

- | | |
|--|--|
| ☐ Attendance | ☐ Psychological evaluations |
| ☐ Transcript/Grades | ☐ Health records |
| ☐ 504 records | ☐ Mental health records |
| ☐ Special Education records (IEPs, evaluations, progress reports) | ☐ Achievement test scores |
| ☐ Email and other written communication | ☐ Other: |
| ☐ Verbal communication and conversation | |
| ☐ Disciplinary reports | |

The purpose of this release of information is:

I authorize the release of student records and confidential information concerning the student listed above. I understand that I have the right to inspect, copy, and challenge the content of the school student records for which I am authorizing release. I also have the right to designate the school student records or specific portions of a school record to be released by this consent. The consequence of failure to consent to release is that records will not be released. This authorization is valid until _____, unless I revoke consent prior to that time. The information released cannot be redisclosed or utilized for any purpose other than as specified above.

Parent/Guardian Signature (if student is under 18)

Date

Student Signature (if at least 18, or at least 12 and mental health records are to be exchanged)

Date

Reset

Print