Issaquah School district No. 411
SPECIAL SERVICES

CONSENT FOR RELEASE AND/OR EXCHANGE OF INFORMATION

Student's Name: Birth date: Age:

School: Grade: Date:

I hereby authorize the release and/or exchange of information regarding the above named child between the Issaquah School District and:

_____

_____

Address City, State , Zip Code

Phone: _____ Fax: _____

The information released shall be:

- ☐ Progress reports
- ☐ Transcript of courses
- ☐ Attendance
- ☐ Clinical reports
- ☐ Medical Information
- ☐ Special Services Assessments/IEP
- ☐ Psychological
- ☐ Other: _____

The reason for this authorization is to provide information to assist in educational planning of student.

I understand that this information obtained will be treated in a confidential manner by the school district under the provisions of the Family Education Rights and Privacy Act (FERPA). FERPA prohibits disclosure of personally identifiable information without consent except in limited circumstances. Please note that if the request is for health or medical information, the medical information received by the district is protected under FERPA privacy standards and not the Health Insurance Portability and Accountability Act (HIPAA).

This authorization is valid from: _____ to _____ .
Date *Date*

Note: For release of medical records, the authorization can be no longer than **90 days** after this authorization is signed.

I understand that my consent for the release of records is voluntary and I can withdraw my consent at any time in writing. Should I withdraw my consent, it does not apply to information that has already been provided under the prior consent for release.

_____ Date: _____
Parent/guardian Signature

_____ Date; _____
Student Signature (age 13 and older, if applicable)

PLEASE MAIL TO:

Attn:
School
Street Address
City, State, Zip