



**Authorization for Release of School Student Records**

Student Name: \_\_\_\_\_ Address: \_\_\_\_\_  
Birth Date: \_\_\_\_\_ City/Zip: \_\_\_\_\_

**I, \_\_\_\_\_, am the parent/guardian of the above-named student, and I hereby grant permission to Kenilworth School District No. 38 to release confidential school student records concerning my student to the following agency or individual for the purpose of educational planning and/or coordination of services:**

Agency/Name: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_  
Street Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

**I further authorize the District and the Agency/Individual listed above to communicate and mutually exchange student record information 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 (including those records designated below)

Or By Category:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Grades/Transcripts               | <input type="checkbox"/> Attendance Records                    | <input type="checkbox"/> Mental Health Records    |
| <input type="checkbox"/> Honors/Awards                    | <input type="checkbox"/> Health Records                        | <input type="checkbox"/> Disciplinary Information |
| <input type="checkbox"/> Outside Evaluations              | <input type="checkbox"/> Test Scores/Data/Reports              | <input type="checkbox"/> Medical Records          |
| <input type="checkbox"/> Class Schedule                   | <input type="checkbox"/> Special Education/504<br>Plan Records | <input type="checkbox"/> Other:                   |
| <input type="checkbox"/> Family Background<br>Information | <input type="checkbox"/> Parents' Names/Addresses              |   |
| <input type="checkbox"/> Grade Level                      | <input type="checkbox"/> Extracurricular Activities            |   |

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, 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/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Student Signature\*: \_\_\_\_\_ Date: \_\_\_\_\_

\*(If student is over 12 years of age and the authorization is for the release of mental health records)