DATE:_____

Clark County School District
Las Vegas, Nevada
Student Support Services Division

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Student Name:_____ Grade:_____ DOB: _____ ID#: _____

Address:_____

I. I hereby authorize the use or disclosure of the specific information as described below.

II. I authorize release of the following records (description of specific information to be used or disclosed: i.e., medical records, academic records, or entire record). Dates of records: From _____ To_____

III. Reasons for use and/or disclosure (i.e., medical care, insurance, personal, attorney, or other specifically described reason):

IV. **Persons/Organizations authorized to make disclosure:**

_____
School/Organization/Medical Provider

_____
Address

_____
City State Zip

Persons/Organizations authorized to use or disclose information:

_____
School/Organization/Medical Provider

_____
Address

_____
City State Zip

V. I understand that this authorization is voluntary and that I may refuse to sign. I understand that I may inspect or obtain a copy of the information to be used or disclosed. I understand that any medical provider to whom this authorization is furnished may not condition treatment, payment, enrollment or eligibility for benefits on whether or not I sign the authorization. The District will maintain the privacy of student education records pursuant to the provisions of the Family Educational Rights and Privacy Act. However, I understand the information used or disclosed under this authorization may be subject to unauthorized redisclosure by the person(s) receiving it and may then no longer be protected.

☐ I authorize release of these records through facsimile transmission (FAX). I understand and agree that should the records be inadvertently transmitted to an unauthorized recipient, through no fault of the sender, I hereby waive any claim against the sender and agree to hold the sender harmless from any and all responsibility for damages, if any, arising from the faulty transmission.

☐ I do not authorize release of records through facsimile transmission (FAX).

VI. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the School in which the authorization was signed I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date_____. If a specific date is not noted, this authorization will expire six months from the date of this request.

Please note: The District does not pay for records. If payment is required, please obtain directly from the parent/guardian.

VII. Parent/Guardian Signature:_____ Date: _____

Requested by _____ _____ _____
Name Title School

INSTRUCTIONS:

1. ALL SPECIAL EDUCATION RECORDS MUST BE REQUESTED AND/OR SENT THROUGH STUDENT SUPPORT SERVICES.
2. Parent, guardian, and/or requesting person are responsible for completion of this authorization.
3. The first portion of Section IV should specify the name and the address of the persons/organization holding the records. The second portion should specify the name and address of the persons/organization to which records are to be sent.

USE THIS FORM WHEN: Obtaining information from other organization, releasing information to other organizations, releasing to parents of 18 year or older student.

Distribution: Original - School or Org. holding records 1st Copy - Confidential Folder 2nd Copy - Parent/Guardian/Adult Student

CCSD CLARK COUNTY SCHOOL DISTRICT