



LOWELL PUBLIC SCHOOLS

Henry J. Mroz Administration Office
155 Merrimack Street
Lowell, Massachusetts 01852
www.lowell.k12.ma.us

AUTHORIZATION FOR INFORMATION AND RECORDS

STUDENT INFORMATION:

LAST: _____ FIRST: _____ MIDDLE: _____ D.O.B: _____

GRADE: _____ GENDER: _____ LASID#: _____ PARENT/GUARDIAN: _____

SCHOOL: _____ ADDRESS: _____

I, _____, (student or parent/legal guardian is student is a minor) understand that in order for Lowell Public Schools to provide the most appropriate educational program and related services for my child, _____, there must be an exchange of information between the persons and/or agency listed below, who have or had knowledge of my child and/or who may be significant providers of service to my child and/or my family, and the staff of the Lowell Public Schools.

I authorize the Lowell Public Schools to ____ Obtain ____ Release the following information (verbal/written) by circling the choices below or by checking "All Records Listed". This RELEASE will be valid for ONE YEAR from the date of signature, unless you specify a different time period (insert alternative time period here)

General Education

All Records	Y N
Educational Records	Y N
(Photo__Video__)	Y N
Attendance	Y N
Discipline Records	Y N
School Health Records	Y N
Current 504	Y N
Two way Communication	Y N
Alternative Placement	Y N
	Y N

Special Education

All Records	Y N
SPED Records	Y N
Current IEP	Y N
Independent Evaluation	Y N
Physical Therapy/Eval	Y N
Occupational Therapy/Eval	Y N
Psychological Eval	Y N
Speech & Language	Y N
Therapy/Eval	Y N
Social History Report	Y N

Special Education

All Records	Y N
Psychiatric Summary	Y N
Discharge Summary	Y N
Detailed Medication History	Y N
Hospital/Medical	Y N
Records	Y N
Medical Summaries	Y N
Protected Info	Y N
(Protected Info Release is required)	
Current Treatment Plans	Y N
(Behavior, Safety, Other)	
Other _____	Y N

I understand that this authorization is subject to revocation at any time, with written notice by the Parent/Student or other responsible party, except to the extent that action has been taken in reliance thereon. I also understand that these records are protected under Federal and State regulations governing the confidentiality of student records.

TO/FROM: _____
Name of Individual/School/Institution/Agency/Physician

Complete Mailing Address

City/Town State Zip

Signature of Parent/Legal Guardian/Student Telephone Number Date