

STUDENT: _____ ID NUMBER: _____ DATE OF BIRTH: _____

Authorization for Release of Records

*Parent permission for the release of your child's records with other persons or agencies.
Used to assist in determining eligibility for Special Education.*

Date: _____

Student: _____

ID Number: _____

School: _____

Grade: _____

I hereby authorize the release of records (enter names of agency or person and full mailing address):

From:

To:

Describe the records to be disclosed:

The reason for disclosing the record(s) is:

I understand that 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: _____

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.

Signature: _____

Date: _____

Parent/Guardian Name: _____

Phone: _____

Email: _____