|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Student’s Full Name:  **RELEASE OF INFORMATION** | |  | | | | | | Birthdate: | |  | | |
| Social Security Number: | | | |  | Race: |  | | | | Sex: |  | |
| School: |  | | | | | | | | | Grade: | |  |
| ***TO:*** | NAME: | |  | | | | | | | | | |
| ADDRESS: | |  | | | | | | | | | |
|  | | | | | | | | | |
| PHONE: | | |  | | | | FAX NUMBER: | |  | | | |

***My permission is granted for the person or agency named above to disclose pertinent information about my child:***

***in discussion with the person or agency named below: AND/OR***  ***by mailing copies or faxing:***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ***TO:*** | NAME: |  | | |
| ADDRESS: |  | | |
|  | | |
| PHONE: |  | FAX NUMBER: |  |

**Specific items, which may be disclosed, include:**

|  |
| --- |
| Medical/Sensory data (including prescribed medications)  Psychological reports |
| Diagnostic reports  Vocational assessment reports |
| Educational records  Other |
| Special Education records |
| Social/Family history information |

|  |
| --- |
| **The stated purpose for this disclosure is:** |
| To determine a psychoeducational eligibility for educational services |
| To develop an educational program to meet the needs of students |
| To coordinate medical, psychological, social, and educational needs |

***Consent is granted for one calendar year, and with the understanding that the receiver agrees not to permit further disclosure without my permission. I understand that I may revoke this authorization at any time.***

**I hereby absolve, release, and discharge you from any liability which might accrue as a result of your disclosure of the information above described and hereby waive, with respect to the above disclosure, any duty of confidentiality which you may have arising from Federal or State requirements.**

**I understand that I will not be denied services for failure to sign this authorization.**

**I understand that the disclosed information may be subject to redisclosure by the recipient and may no longer be protected by 45CRFR 164.508**

***I hereby certify that I have read this release, I understand it, and agree to its terms.***

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Signature of parent/guardian/surrogate parent Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of student if applicable Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WITNESS SIGNATURE Date

A COPY, INCLUDING DIGITAL COPIES, OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AS THE ORIGINAL