Authorization to Release/Exchange Confidential Information

Student Name: _____ **Grade:** _____ **Date:** _____ **DOB:** _____

Address: _____ **Gender:** _____

City: _____ **Home Phone:** _____

State: _____ **Zip Code:** _____ **Home School:** _____

Today's Date: _____

District Contact Person: _____ **Phone:** _____

Position: _____ **Fax Number:** _____

I, as a parent or legal guardian of the above named student, give my consent to to release or receive confidential communication and records regarding my child from an outside person, school, or agency as indicated below.

☐ Release ☐ Receive

Name: _____ Name: _____

Address: _____ Address: _____

Phone: _____ Phone: _____

The following information is requested to assist in education planning and coordination of services:

☐ Psychological Reports	☐ Educational Records/Reports/Evaluations/IEP
☐ Social Work Reports	☐ Therapy Reports/Progress
☐ Psychiatric Reports	☐ Telephone Contacts
☐ Medical/Hospital Records/Reports	☐ E-mail Contacts

☐ Other: _____

Under the Illinois Mental Health and Developmental Disabilities Confidentiality Act, Confidential Reports from other organizations cannot be re-released as part of the school record. Such information should be obtained directly from the specific organization. Records covered under this act include psychological reports and other mental health records and require student signature if 12 years or older.

I understand that, as parent or guardian, I control access and release of student records to all individuals or agencies or school other than the school in which my child is enrolled. I also understand that I have the right to inspect, copy and challenge the educational relevancy of my child's school records.

I further understand that I can revoke my consent to release/exchange confidential information at any time by sending written notification to the district contact listed above.

Parent/Guardian Signature: _____ Date: _____

Student Signature (12 yrs. or older*): _____ Date: _____

Witness Signature: _____ Date: _____

*Note: If student is between 12 and 17 years of age and refuses to authorize the release of mental health records, the student's refusal can be overruled by certified school/mental health personnel upon a showing to _____ (school administrator or certified/licensed therapist) that the release is believed to be in the best interest of the individual).

This consent is valid until this specific date: _____

Distribute copies to the Student's Temporary Record, Parent, and District Contact Person; copy to Main Special Education File, if appropriate.