AUTHORIZATION FOR RELEASE/EXCHANGE OF INFORMATION

I/we hereby authorize the exchange of communications and the release/exchange of the following records concerning _____[student's name] between the agents and employees of _____[school district's or special education cooperative's name] and: _____[student's date of birth]

Name/Title: _____
Agency/Organization: _____
Address: _____
Phone/Fax: _____ E-mail: _____

I/we hereby authorize that the following information will be released/exchanged:

☐ All permanent records (including, but not limited to, basic identifying information, birth certificate or other proof of student's identity, academic transcript, attendance records, health records and, where applicable, scores received on all State assessments administered in grades 9-12 and designation of student's achievement of the State Seal of Biliteracy or State Commendation Toward Biliteracy)

☐ All temporary records (including, but not limited to, scores on State assessments administered in grades K-8, discipline records, health-related information, accident reports, family background information, psychological evaluation reports, aptitude and achievement test results, report cards, honors and awards, progress monitoring information, IDEA/special education records, and Section 504 records)

☐ Other [Circle one]: Psychiatric, Neurological, Physical Therapy, Occupational Therapy, Physical/Medical/Dental, Ocular, Other: _____

These disclosures are authorized pursuant to the *Family Education Rights and Privacy Act* (20 U.S.C. Section 1232g), the *Illinois School Student Records Act* (105 ILCS 10/1 *et seq.*), and the *Illinois Mental Health and Developmental Disability Confidentiality Act* (740 ILCS 110/1 *et seq.*),* and are to be made for the purpose of:

☐ Educational evaluation and/or planning
☐ Other [specify]: _____

*Prior to the release of protected health information, health care providers may require the parent/guardian to execute an additional authorization form to comply with the *Health Insurance Portability and Accountability Act* ("HIPAA").

I understand that I have the right to inspect and copy the information to be disclosed, challenge its contents, and limit my consent to designated records or portions of the information contained in those records. I also understand that my refusal to consent to the exchange of records and communications could result in incomplete and/or inappropriate educational planning for the student. This consent expires one year from the date indicated below. However, I understand that I have the right to revoke this consent in writing at any time.

_____ _____
Parent/Guardian Printed Name Date

_____ _____
Parent/Guardian Signature Date

_____ _____
Witness Signature [required for mental health/ developmental disability records] Date

_____ _____
Student Signature [required for mental health/ Developmental disability records, if student is age 12 or older] Date