Edwardsville Community School District #7

708 St. Louis Street, Edwardsville, Illinois 62025
(618) 655-6013 Fax: (618) 655-6035
Adam Garrett, Director of Student Services & Special Education

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

Request for Release of Information and Temporary Records

The student or parent/guardian has requested the following records for this student be released to:

The Office of Student Services and Special Education to the attention of :_____

Agency Information:

Name:_____

Address:_____

_____

Contact Person:_____

Phone Number:_____

FAX Number:_____

Student Information:

Name:_____

Parent/Guardian Name: _____

Address: _____

Home Phone:_____

D.O.B.:_____Grade:_____

Home School: _____

Please release the following records and information:

Records to Release:

☐ Academic Records

☐ Medical Information

☐ Mental Health Records (Must have student signed consent if 12 years of age or older)

☐ Current **I**ndividualized **E**ducation **P**lan

☐ Specialized Reports (PT, OT, Speech)

☐ Case Study Components-Psychological, Social/Health History

☐ Verbal/Written Communication (as appropriate)

☐ Other (specify) Eligibility Meeting Summary, etc.

_____

Reason For Request:

☐ Student is transferring to/from our district and has received special education services in the previous school.

☐ Student is in the collaborative process and information is requested to assess performance difficulties

☐ Student temporary records are to be destroyed due to the Records Act (five years after permanent withdrawal or graduation) and individual is wishing copies of records.

☐ Another agency/district is requesting the records for possible services for the above named student.

I, _____ as the parent/guardian of the above named student, do hereby consent to the release and exchange of confidential information as listed above to the aforementioned agency and the Edwardsville Community School District #7. I understand that such consent permits the exchange of both verbal and written information between the agency listed above and the Edwardsville School District with such information being solely and exclusively used in assisting the District in providing educational services the student.

I acknowledge that I had the right to inspect, copy or challenge the educational records of the Edwardsville Community School District #7 prior to the exchange, and I had the right to limit the extent of the inspection or disclosure.

I understand that my refusal to sign will result in the documents or information not being released. Prior to the disclosure, I further understand I have the right to revoke this consent at any time if the revocation is provided in writing.

_____ _____
(Name of Person Securing Release) (Date)

_____ _____
(Signature of Parent/Legal Guardian) (Date)

_____ _____
(Signature of Student if Required) (Date)

Expiration Date:_____(One year from Signature Date)