

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:

Student Information:

Name: _____
Address: _____

Contact Person: _____
Phone Number: _____
FAX Number: _____

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 Individualized Education Plan
- _____ 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)**