CONSENT FORM AUTHORIZING RELEASE OF STUDENT DATA/RECORDS

Student Name: _____ Date of Birth _____

Name of School_____ School ID # _____

Student Address _____

Home Telephone #: _____

Parent/Legal Guardian (1) Mobile Telephone # _____

Parent/Legal Guardian (2) Mobile Telephone # _____

I authorize the **[BLANK]** School Division to release to the individual or Agency identified below identifying educational/medical data and records (the "Records") of the student listed above. I understand that in addition to educational records and data, such Records may also contain health information pertaining to diagnosis and treatments, immunization records, suspensions/office referral data, attendance data, referrals to student service teams, as well as written communications with school staff related to mental health interventions.

Time Period During Which Release of Student/Data is Authorized:

From: Date this form is signed below.

Until: _____

To Authorized Individual or Agency:

Name and Title: _____

Agency Name (if applicable): _____

Address (1): _____

Address (2): _____

Email Address: _____

Phone Number: _____

Fax Number: _____

Signature of Parent/Guardian: _____

Name of Parent/Guardian: _____

Relationship to Student: _____

Date: _____

Witness: _____