

AUTHORIZATION FOR RELEASE/EXCHANGE OF INFORMATION

I, _____, hereby authorize the exchange of communications and the
(name of parent or guardian)
release/exchange of the following records concerning _____
(name of student and student's date of birth)
between _____ agents and employees and
(name of district or cooperative)

(name of person or agency)

These disclosures are authorized pursuant to 20 U.S.C. Section 1232g, 105 ILCS 10/1 et seq., and 740 ILCS 110/1 et seq.,* and are to be made for the purpose of educational planning for _____. I understand that I have the right to inspect and copy the

(name of student)
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 _____.

(name of 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 SIGNATURE

DATE

STUDENT SIGNATURE (for mental health/
developmental disability records, if student is age 12 or older)

DATE

WITNESS SIGNATURE (for mental health/
developmental disability records)

DATE

* NOTE: 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 (AHIPAA@).