BEACH PARK COMMUNITY CONSOLIDATED SCHOOL DISTRICT #3
11315 W Wadsworth Rd.
Beach Park, IL 60099

Jorge Seda
Director of Student Services
EL Coordinator
847-599-5056
FAX 847-360-1130

STUDENT RECORDS
AUTHORIZATION TO REQUEST / RELEASE COMMUNICATIONS AND RECORDS

Student's Name:_____ Date of Birth:_____

I AUTHORIZE:

Beach Park CC School District #3
11315 W. Wadsworth Road
Beach Park, IL 60099
Telephone: 847/599-5056
Fax: 847/360-1130

TO EXCHANGE INFORMATION WITH:

Name:_____

Street:_____

City/State/Zip:_____

The affixed signature(s) gives permission to Beach Park CC School District #3 and to the agency or persons to whom this form is addressed, to exchange restricted/confidential communications and records as listed regarding the above named individual. These communications and records are intended for use in making decisions regarding educational and therapeutic evaluations and planning as mandated by the State and/or Federal law and are accessible to parents upon request.
The release will be copied and sent with the information requested. This authorization grants permission to Beach Park CC School District #3 to establish phone contact, if necessary, for the purpose of requesting records and information to the student's educational and therapy program.

Description of Records Requested:

_____ Student Temporary Records
_____ Medical/Physical Exam/Health Records
_____ Educational Assessment
_____ Psychological Evaluation
_____ Psychiatric Evaluation/Reports
_____ Education Progress Reports
_____ Audiological Reports
_____ Education Progress Reports

_____ Student Permanent Records
_____ Ophthalmologic/Ocular
_____ Dental
_____ Hearing and Vision Screening
_____ Speech and Language
_____ OT and PT Reports
_____ Treatment and Progress Notes (Hospitalization)
_____ Other

The information provided to District 3 will become part of the student's records and will be shared with the appropriate personnel responsible for the implementation of the student's program, in accordance with the Federal and State law.

ILLINOIS MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES CONFIDENTIALITY ACT.
The authorization will be good for one year from the date of this signing, _____, and limited to only that information I have requested above to be sent to the facility named herein and that it not be further disclosed or used for any other purpose other than as stated in the authorization. It is further understood that I have been advised by the facility that I have the right to revoke the consent at any time during it's validity.

I understand that my refusal to consent to the release of the information specified above will prevent disclosure of such information to the facility named herein.

Parent/Guardian:_____ Date:_____

Student Signature:_____ Date: _____
(Required if 12-17 years and Mental Health records are being released)

Witness: _____ Date: _____
(Required if 12-17 years and Mental Health records are being released)

Mental Health Records (only): Adult 18 or over - Parent/guardian and child; If 12 through 17 - Parent/Guardian; If child under 12 or patient adjudicated incompetents