

Your School/District \_\_\_\_\_

SpEd 12 04.08

Your City \_\_\_\_\_

## Consent for Disclosure of Confidential Information

Student's name: \_\_\_\_\_ Date of consent: \_\_\_\_\_

Date of birth: \_\_\_\_\_

We are asking that you authorize the persons or agencies named below to disclose to each other confidential information regarding the above named student.

\_\_\_\_\_  
Name and title of school staff representative

**AND**

\_\_\_\_\_  
Representative/Agency

\_\_\_\_\_  
Name of school

\_\_\_\_\_  
Name of Representative /Agency

\_\_\_\_\_  
Address:

\_\_\_\_\_  
Address:

\_\_\_\_\_  
FAX #:

\_\_\_\_\_  
FAX #:

### RECORDS TO BE RELEASED/DISCLOSED

### PURPOSE OF RELEASE/DISCLOSURE

☐ Independent Evaluations, Medical Records, Psychiatric Evals.

☐ To assist the IEP committee in educational planning

☐ Vocational Testing. ITP

☐ Other \_\_\_\_\_

☐ Other Records of outside agency \_\_\_\_\_  
Name of Outside Agency

Please check the appropriate boxes below.

☐ Yes ☐ No I have been fully informed in my native language or other mode of communication and understand the school's request for my consent, as described above. This information will be disclosed upon receipt of my written consent.

☐ Yes ☐ No I understand that my consent is voluntary and may be revoked anytime. However, I understand that revocation is not retroactive (i.e., It does not negate an action that has occurred after the consent was given and before the consent was revoked).

☐ Yes ☐ No I give my permission for the identified records to be released/disclosed to the above named person(s) / agency(ies).

\_\_\_\_\_  
Signature of Parent, Guardian, Surrogate Parent or Adult Student

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Interpreter, if used

\_\_\_\_\_  
Date

Please return this form to:

\_\_\_\_\_  
School Staff Representative

at: \_\_\_\_\_  
School

For More Information Call:

\_\_\_\_\_  
School Staff Representative

at: \_\_\_\_\_  
Telephone Number