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.

_____ **AND** _____

Name and title of school staff representative | Representative/Agency

_____ _____

Name of school | Name of Representative /Agency

Address: | Address:

FAX #: _____ | FAX #: _____

RECORDS TO BE RELEASED/DISCLOSED

☐ Independent Evaluations, Medical Records, Psychiatric Evals.

☐ Vocational Testing. ITP

☐ Other Records of outside agency _____
Name of Outside Agency

PURPOSE OF RELEASE/DISCLOSURE

☐ To assist the IEP committee in educational planning

☐ Other _____

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retroactive (i.e., It does not negate an action that has occurred after the consent was given and before the consent was revoked).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:

_____ at: _____

School Staff Representative | School

For More Information Call:

_____ at: _____

School Staff Representative | Telephone Number