AUTHORIZATION FOR RELEASE OF RECORDS AND COMMUNICATIONS

BY SCHOOL DISTRICT

See instructions for assistance in completing this form.

1. I, _____, □ student, □ parent □ legal guardian □ "primary caretaker," authorize

_____ to: □ release the records marked below
Institution/Agency/Practitioner

for inspection and/or copying by, and/or □ communicate with, the recipient(s) noted below regarding,

_____, ____/____/____, for the purpose of: _____
Client/Student Birthdate

_____.

2. Recipient(s):_____(____)_____,
Name & Title Phone

_____
Agency, Street Address, City, State, Zip Code

3. Information may be disclosed/obtained by (circle all that apply): Mail, In-Person, Phone, E-mail or FAX (for urgent/emergency needs). If no method is identified, any method may be used.

4. This consent is valid for a period of one year or until ____/____/20___, which ever is shorter. **I understand that I have a right to revoke this authorization at any time except to the extent that the program or person which is to make the disclosure has already acted in reliance on it. Any revocation must be in writing and must be sent/given to the school's Records Custodian or _____. Furthermore, I understand that no revocation shall prevent disclosure of records and communications until it is received by the person authorized to disclose records and communications.**

RECORDS TO BE RELEASED

The records released shall cover the dates of _____ to _____ (Optional)

Evaluation/Assessment	Treatment	Education Records	
□ Screenings	□ Treatment Plan	□ Grades/Transcript	□ Attendance
□ Psychological Report	□ Treatment Records	□ Health Records	□ Discipline Records
□ Psychiatric Report	□ Progress Reports/Summaries	□ Test Scores	□ IEP/504 Plan
□ Social Work Report		□ Speech, OT, PT Reports	□ Behavior Mgt. Plan
□ Educational Testing		□ Service Records/Logs	
□ Speech/OT/PT Assessments			
□ Standardized Academic Test Results			
□ Linguistic Testing for English Learners			

□ Reports/Evaluations received from: _____
Institution/Agency/Independent Practitioner

□ Other _____

*It is my full understanding that, the records and communications to be disclosed **will** include sensitive information such as evaluation, habilitation/treatment information for mental health, developmental disabilities, alcohol or substance use/abuse, HIV/AIDS or exposure to sexually transmitted diseases **unless specifically checked below for exclusion,** if in the District's possession and with proper signatures consenting to release:*

□ *Mental Health* □ *Developmental Disabilities* □ *Alcohol/Substance Abuse*

□ *HIV/AIDS* □ *Exposure to Sexually Transmitted Diseases* □ *Other* _____

5. **ACKNOWLEDGEMENTS**

School Records: I understand that I have the right to inspect, copy, and challenge the content of the school student records for which I am authorizing release. I also have the right to designate the school student records to be released or to identify specific portions of a school record to be released by this consent. Any such limitations have been noted above.

Mental Health Records: I fully understand the nature and purpose of this authorization, that I have the right to inspect and copy the records to be released, and that I may revoke this consent at any time. The consequences, if any, of my refusal to consent to the release of these records have been explained to me as: _____

_____

_____ _____

Authorized Signature Date

_____ _____

Signature of Minor if 12 years of age or over Date
(Mental Health/Substance Abuse/HIV/AIDS and/or STD)

_____ _____

Signature of Witness (Mental Health Records) Date

Notice to Agent/Person Receiving Records. Under the provision of the the *Federal Education Rights Privacy Act*, 20 USC 1232g(b)(4)(B); the ***Illinois School Student Record Act*, 105 ILCS 10/6(d); the *Mental Health and Developmental Disabilities Confidentiality Act*, 740 ILCS 110/5(d); and/or the *Aids Confidentiality Act*, 410 ILCS 305/10, you may not redisclose any of the information received without first obtaining specific, written authorization conforming with the appropriate Act.**

To the extent that the information to be released addresses substance abuse diagnosis or treatment, this information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.