



Consent for Disclosure of Confidential Information

Student name:	Grade:	DOB:
School:		Date of request:

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	Purpose of Release/Disclosure
<input type="checkbox"/> Independent Evaluations, Medical Records, Psychiatric Evals. <input type="checkbox"/> Vocational Testing, ITP <input type="checkbox"/> Other Records of above-named outside agency	<input type="checkbox"/> To assist the IEP committee in educational planning <input type="checkbox"/> 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retroactive (i.e., It does not negate an action that has occurred after the consent was given and before the consent was revoked).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