Request for Release or Secure Confidential Information

(Not required for release to another Administrative Unit)

Legal Name of Student	**Date**
State Student ID (SASID)	**Date of Birth**

This permission shall be valid for the following duration. Beginning ___ and shall terminate___.

Indicate Consent		**Records/information to be released or secured**
☐ Yes	☐ No	☐ Audiometric
☐ Yes	☐ No	☐ Educational
☐ Yes	☐ No	☐ IEP
☐ Yes	☐ No	☐ Medical
☐ Yes	☐ No	☐ Occupational Therapy
☐ Yes	☐ No	☐ Psychiatric
☐ Yes	☐ No	☐ Psychological
☐ Yes	☐ No	☐ Physical Therapy
☐ Yes	☐ No	☐ Social Work
☐ Yes	☐ No	☐ Speech/Language
☐ Yes	☐ No	☐ Other list:
☐ Yes	☐ No	☐ Other list:

	From	**To**
Agency		
Address		
City, State, Zip		

All information released or secured will be in compliance with Family Education Rights and Privacy Act and the Colorado Open Records Law. No additional information will be released or secured without prior approval from the parent, except as provided by law.

Parental Consent

I understand that consent is voluntary and may be revoked at any time in writing. I hereby authorize the transfer of information as indicated above.	
Parent/Guardian/ESP Signature	Date

☐ Date consent received by District/Administrative Unit