INDIAN PRAIRIE SCHOOL DISTRICT 204

AUTHORIZATION FOR RELEASE OF INFORMATION

Student's Name: _____ Date of Birth: _____

Address: _____ Telephone: _____

City/State: _____ Zip: _____

I authorize, _____
(District #204 School Information)

_____

☐ To Obtain From _____
☐ To Disclose To (Agency, School, Therapist, Etc.)

_____

_____

The Following Information (Check all that apply and date of reports):

☐ Psychological Data/Reports _____
☐ Social Developmental Study _____
☐ Mental Health Assessments _____
☐ Summary of Treatment _____
☐ IEPs and Educational Data/Records _____
☐ Medical History/Exams/ Evaluations _____
☐ Psychiatric Evaluations _____
☐ Other (Specify) _____ _____

In the Form of (Check all that Apply):

☐ Written Report
☐ Facsimile
☐ Other (Specify) _____
☐ Telephone Conversation
☐ Email

The purpose or need for this information release is: _____

This consent expires: _____
(Date not to exceed one calendar year)

This person or agency to whom this information is disclosed may not re-disclose this information unless I, the undersigned, specifically consent to such disclosure.

I, the undersigned, understand that I have the right to inspect and copy the information to be disclosed, to challenge the contents in accordance with the Illinois School Student Records Act, and to limit consent or disclosure to designated records or portions of information contained therein.

I, the undersigned, have the right to revoke this consent at any time in writing. I understand that my refusal to permit such transmittal may limit the available database for diagnostic evaluation and treatment services.

The authorization form is in compliance with the requirements of Article VII, Rules and Regulations to Govern School Student Records.

_____ _____
Parent/Guardian Signature(s) Date Witness Date
(if Student is less than 18 years)

_____ _____
Student Signature (If over age 12) Date Witness Date
(for mental health/developmental disability records, if student is age 12 or older, but less than 18 years)