Mid-State Special Education
202 Prairie Street, PO Box 46, Morrisonville, IL 62546, Phone: 217-526-8121, www.midstatespec.org

Authorization For Release/Exchange of Information

Student Name: ______________ **Grade:** ______ **Date:** ________ **DOB:** ________

I hereby authorize:

Name/Title/Agency: ______________________ Phone: ____________
Address: ______________________ Email: ____________

and

School Personnel: ______________________ Phone: ____________
Address: ______________________ Email: ____________

to exchange information/records for the purpose listed below.

Description:

I hereby authorize that the following information will be released/exchanged (check all that apply):

- ☐ All permanent records (including, but not limited to, basic identifying information, academic transcript, attendance records, health records and scores received on all State assessments administered in grades 9-12, where applicable)
- ☐ All temporary records (including, but not limited to, scores on State assessments administered in grades K-8, discipline records, health-related information, accident reports, aptitude and achievement test results, report cards, progress monitoring information, special education records, and Section 504 records)
- ☐ Mental health record(s) date(s) (specify) ______________________
- ☐ Family History
- ☐ Other (specify) ______________________

Purpose: This information will be used for the following purpose(s):

- ☐ Educational evaluation and program planning.
- ☐ Health assessment and planning for health care services and treatment in school.
- ☐ Referral for community supports/agencies
- ☐ Other (specify) ______________________

Authorization: I understand that I have the right to inspect and copy the information to be disclosed and exchanged, challenge its contents, and limit my consent to designated records or portions of the information contained in those records. I also understand that my refusal to consent to the exchange of records and communications could result in incomplete and/or inappropriate educational planning for the student. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I also understand that my revocation of this authorization will not be effective for actions taken by the school district or third party in reliance upon my authorization and prior to notice of my revocation. This authorization will automatically expire one (1) year after the date of the signature.

______________________ ____________
Parent Signature Date

______________________ ____________
Student Signature (For mental health/developmental disability records, if student is age 12 or older) Date

______________________ ____________
Witness Signature (for mental health/developmental disability records) Date

______________________ ____________
Records Custodian Printed Name Date

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Records Custodian Signature