

Authorization to Release School Records and
Consent for Use of Information

1) Name and Address of School, Individual or Agency to Release Information:

Name _____
Address _____
City/State/Zip _____
Telephone _____ Fax _____

2) Student Information:

Student Name (full legal name) _____ Birthdate _____
Address _____ Current Grade _____
City/State/Zip _____ Phone _____

3) Records are to be released to: EWS Team SRO Other _____

4) Records to be Released: _____ All records needed (including but not limited to all items below.)

<input type="checkbox"/> Transcript of subjects, grades & test records	<input type="checkbox"/> IEP (Individual Education Plan)
<input type="checkbox"/> Attendance records	<input type="checkbox"/> Health & immunization records
<input type="checkbox"/> Evaluation Team Report (must be sent with all IEPs)	<input type="checkbox"/> Psychological Reports
<input type="checkbox"/> Discipline records (including suspensions & expulsions)	<input type="checkbox"/> On-going communication
<input type="checkbox"/> Standardized Test Scores	<input type="checkbox"/> Intelligence Test Scores
<input type="checkbox"/> Other _____	

5) Purposes for which records may be used:

Assessment Coordination of Services EWS Team Intervention Other (Specify) _____

I hereby authorize the release of the above-referenced records for the purpose of assessment, evaluation, intervention and coordination of services by the Early Warning System Team only. It is my understanding that any information received by the Early Warning System Team will not be further released without my written consent and that the Early Warning System Team members will take all necessary steps to protect the confidentiality of the records and of my child's/ward's/my identity. I understand that the information released may be copied and used only by the Early Warning System Team. By signing below, I acknowledge that I have been informed of my rights to refuse to sign this form, and any conditions related to my consent or refusal, and that I am entitled to receive a copy of the signed form. I further understand that I may revoke this consent at any time. I understand that this authorization will expire at the end of the current school year.

I do not consent to the release of any information.

Parent/Guardian Signature: _____ Printed Name _____ Date: _____

Student Signature (if 18 or older): _____ Printed Name _____ Date: _____

Witness Signature _____ Witness Printed Name _____ Date: _____

For School Use Only:

Date Requested: _____ Initials: _____ Date Sent: _____ Initials: _____

Date Received: _____ Initials: _____

Revocation of consent _____
(Parent/Guardian/Student signature) (Date)