

Date Sent: _____

Faxed Emailed Mailed

Sent By: _____



AUTHORIZATION TO RELEASE CONFIDENTIAL RECORDS

This document is a reciprocal release of information form

To: _____
Records Custodian

From: _____
Person Requesting Records

School/Agency

School/Agency

Address

Address

City/State/Zip

City/State/Zip

Phone/Fax/Email

Phone/Fax/Email

YOU ARE HEREBY AUTHORIZED AND INSTRUCTED TO RELEASE CONFIDENTIAL INFORMATION REGARDING:

First Middle Last

Date of Birth

Grade Level

REASON FOR REQUEST (OPTIONAL):

- Educational Evaluation and Program Planning
- Maintenance of Student Records
- Other: _____

- Medical Problems Related to Learning
- Medical Evaluation and Treatment
- * For IEP only - Date of upcoming IEP meeting

PLEASE SPECIFY THE RECORDS TO BE RELEASED:

- Psychological Report
- Educational Evaluation
- Social History
- I.E.P. (Minutes & Goals/Obj.)
- Hearing / Vision Screening Results
- Medical Exam Report Form

- Psychiatric Evaluation
- Eligibility Report
- Anecdotal Records
- Medical Records
- Other: _____

Authorization:

This authorization is valid for one year or as specified: _____ **It will expire on:** _____

I hereby represent that I lawfully possess the parental authority (*as parent, guardian or adult student*) to authorize the release of the records specified above, and I agree to allow representatives of the school system to check my driver's license or government issued photo identification in order to verify my identity. (*If this request is delivered other than in person, I understand that my signature must be notarized*) I understand that the Cherokee County School District will rely upon this representation in considering this request for records. I understand that providing consent to release records is voluntary on my part. The Cherokee County School District may impose nominal fees for copying in certain circumstances. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I recognize that health records, once received by the local education agency (LEA), may no longer be protected by HIPAA, but they will become education records protected by the Family Educational Rights and Privacy Act (FERPA).

Parent/Guardian/Adult Student Printed Name

Relationship to Student

Parent/Guardian/Adult Student Signature

Date

(Required if ID Not Verified)

Sworn to and subscribed before me this

_____ day of _____, 20____

Notary Public

My Commission Expires: _____