



NOTICE FOR RELEASE/CONSENT TO REQUEST CONFIDENTIAL INFORMATION

Request Release

Student's Name: _____	DOB: _____
Campus: _____	Grade: _____ Age: _____

We are asking that you authorize the person or agency named below to release/ to request specified records containing confidential information regarding the above named student.

TO:

FROM:

Name & Position of Staff Person

Name & Position of Staff Person Making Request

Name of School District or Agency

Name of School District or Agency

Address

Address

City/State/Zip

City/State/Zip

Records To Be Released/Requested

Purpose of Disclosure

Education Placement Other: _____

Comprehensive Individual Assessment Report ARD/IEP Medical Reports

Other _____

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Check **Yes** only if you agree that the statements are correct. If the statements are not correct, check **No**. If you wish to have more information or if you have any questions, please call **(214) 443-1227** and ask for _____.

Yes No I have been fully informed and do understand the school's request for my consent for release of my child's records, as described above. This information will be released upon receipt of my written consent.

Yes No I understand that my consent is voluntary and may be revoked in writing at any time before records are sent.

Signature of Parent, Guardian, Surrogate Parent, or Adult Student

Date

Signature of Interpreter, if used

Date