

**Exceptional Student Education
PARENTAL PERMISSION FOR
RELEASE OF INFORMATION OR REQUEST FOR REVIEW
OF STUDENT INFORMATION**

Date: _____

I, _____

hereby authorize: (include name of person to contact)

to release the following portion of the records regarding my child

Legal Name	Birthdate	School
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which includes:

1. All psychological
2. and educational data,
3. including tests of intellectual process, and academic abilities, present levels of subject area performance, projectives, adaptive and behavior scales, social/medical history, and individual educational plans.
4. Other _____

TO: _____

THESE RECORDS MAY NOT BE RELEASED TO ANOTHER PARTY AND/OR AGENCY WITHOUT PRIOR APPROVAL OF THE PARENT/GUARDIAN AND/OR ELIGIBLE STUDENT. ANY RELEASE OF MEDICAL DATA IS SUBJECT TO HIPPA REQUIREMENTS.

TRANSITION PLANNING (Consent for mutual exchange of information for transition services):

I hereby authorize the exchange of information and records pertaining to the above named child among the County School District, the members of the interagency community transition team, Department of Children and Families, Vocational Rehabilitation, Agency for Persons With Disabilities, Alcohol, Drug Abuse and Mental Health, Division of Blind Services, Community College System, State University System, Private Industry Council, and other agencies and providers including other schools, hospitals, clinics, physicians, psychologists, etc. that have had significant contact with my child. Information will not be disclosed to any party except personnel with a legitimate educational interest without prior written consent of the parent or legal guardian. I understand that this provides consent to release information and to invite agency representatives to IEP meetings.

Authorized Signature/Date

Relationship

Address

City

Zip

Home Telephone

If no telephone, please give a telephone number where you can be contacted.