**Authorization for Exchange of Confidential Information**

School Year:

Last Name: First: Middle: Student ID Number Date Of Birth

Street:

City: State: Zip: Phone:

Parent Address: Medicaid #: Home:

 Work:

Grade:

Gender:

Case Manager:

School:

As the parent of legal Guardian of the above named child, I hereby grant my permission to Nippersink School District 2 to release/receive confidential information concerning my child to/from:

The purpose of this authorization is:

I understand that my permission covers the release of permanent and temporary record, as well as the release of confidential record and reports. I also understand that I have the right to inspect and copy school records, to challenge the contents of these records and/or limit this consent to specific records or portions of records which I have designated below:

 Psychological Evaluation Medical Records

 Psychiatric Evaluation Speech/Language Reports

 Health Records Individualized Education Program (IEP)

 Social Development Study/Records Other:

This authorization is good for 1 calendar year.

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 *Date* *Signature of Parent/Guardian or Adult Student over age 18*

Disposition of records:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 *Date* *Name/Title*