**Enter LEA Name Here**

**Authorization for Release of Records**

*(Parent permission for the release of your child’s records with other persons or agencies. Used to assist in determining eligibility for a Section 504 plan.)*

|  |  | **Date:** | Enter date |
| --- | --- | --- | --- |
| **Student:** | Enter name |  |  |
| **School:** | Enter name of school | **SSID:** | Enter state student ID number |
| **Grade:** | Enter grade | **DOB:** | Enter date of birth |

I hereby authorize the release of records (enter names of agency or person and full mailing address):

| **From:**  | Enter text | **To:**  | Enter text |
| --- | --- | --- | --- |

**Describe the records to be disclosed:**

| Enter text |
| --- |

**The reason for disclosing the record(s) is:**

| Enter text |
| --- |

I understand that information obtained will be treated in a confidential manner by the school district under the provisions of the Family Education Rights and Privacy Act (FERPA). FERPA prohibits disclosure of personally identifiable information without consent except in limited circumstances. Please note that if the request is for health or medical information, the medical information received by the district is protected under FERPA privacy standards and not the Health Insurance Portability and Accountability Act (HIPAA).

This authorization is valid from: Enter date to Enter date

Note: For release of medical records, the authorization can be no longer than 90 days after this authorization is signed.

I understand that my consent for the release of records is voluntary and I can withdraw my consent at any time in writing. Should I withdraw my consent, it does not apply to information that has already been provided under the prior consent for release.

| **Parent / Guardian Name:** | Enter name |
| --- | --- |
| **Signature:** |  | **Date:** | Enter date |
| **Phone:** | Enter phone number | **Email:** | Enter email address |