Consent for Release of Educational Records

**Why am I being asked to sign this form?**

Your student is receiving care with *[insert name of school-based health provider].* Sometimes, information contained in your student’s school record can help *[insert name of school-based health provider]* provide your student with better care. For example, clinic staff may want to access your student’s class schedule in order to arrange appointments or to your contact information in order to communicate with you. School staff may want the ability to make a referral or participate with clinic staff on a multidisciplinary support team. The school and school staff at times need your permission to share information from your student’s record for these purposes. By signing this form, you are giving permission for the school to share the information outlined below with *[insert name of school-based health provider]* for the purposes of assessment, care coordination, treatment, or referral.

To:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(*Name of school, school district, or education agency holding the educational record*)

I authorize you to release information from the education record of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *(state name of student*) to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (*State the party or class of parties to whom the disclosure may be made* )

The type of information that I authorize you to release is: (*Please initial all relevant boxes*)

* All records
* Parent/guardian contact information
* Attendance information
* Class schedules and teachers
* Transcripts and grades
* Health records, such as immunization records, medications, and health care plans
* Special education records, such as 504 or individualized education plans
* Assessment and testing results
* Teacher reports
* Disciplinary records
* Other: (*please specify*)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This consent is valid until the following date or event:

*(Specify expiration date or event)*

I understand that I may request a copy of any records disclosed pursuant to this release.

Parent/Guardian/Authorized Signatory\* Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian/Authorized Signatory Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_

*\*Parent/guardian/authorized rights holder must sign if student is younger than 18 years old. Student must sign if student is age 18 or older.*

***This form meets the requirements of 34 CFR § 99.30 of the Family Educational Rights and Privacy Ac******t***