THOMAS | GREENBRIER | IVY HILL | OLIVE | PATTON
SOUTH | DRYDEN | WESTGATE | WINDSOR

DEPARTMENT OF STUDENT SERVICES 1200 S. Dunton Ave, Arlington Heights, IL 60005 847.758.4875

Authorization to Release/Exchange Confidential Information

Student Name: _____ **School:** _____ **DOB:** _____

I, as a parent or legal guardian of the above named student, give my consent to **Arlington Heights School District 25** to release or receive information on my child from a person, school, or agency as indicated below.

☐ Release ☐ Receive

Name: Address: Phone: Email:

The following information is requested to assist in the educational planning and coordination of services:	
☐ Psychological Reports ☐ Social Work Reports ☐ Psychiatric Reports ☐ Medical/Hospital-Records/Reports	☐ Educational Records/Reports ☐ Evaluations, IEP, Progress Notes ☐ Telephone Contacts ☐ E-mail Contacts ☐ Observations
☐Other:	

Under the Illinois Mental Health and Developmental Disabilities Confidentiality Act, Confidential Reports from other organizations cannot be re-released as part of the school record. Such information should be obtained directly from the specific organization. Records covered under this act include psychological reports and other mental health records and require student signature if 12 years or older.

I understand that, as the parent or guardian, I control access and release of student records to all individuals or agencies or schools other than the school in which my child is enrolled. I also understand that I have the right to inspect, copy and challenge the educational relevancy of my child's school records.

I further understand that I can revoke my consent to release/exchange confidential information by sending written notification to the school district.

Parent/Guardian Signature: _____ Date: _____

Student Signature (12 yrs. or older): _____ Date: _____

Witness Signature: _____ Date:_____

This consent is valid for one year unless specified, valid until: _____