



**Arlington Heights**  
SCHOOL DISTRICT 25

Embracing Today – Inspiring Tomorrow

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

### Authorization to Release/Exchange Confidential Information

Student Name: \_\_\_\_\_ Grade/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:	
<input type="checkbox"/> Psychological Reports <input type="checkbox"/> Social Work Reports <input type="checkbox"/> Psychiatric Reports <input type="checkbox"/> Medical/Hospital-Records/Reports	<input type="checkbox"/> Educational Records/Reports <input type="checkbox"/> Evaluations, IEP, Progress Notes <input type="checkbox"/> Telephone Contacts <input type="checkbox"/> E-mail Contacts <input type="checkbox"/> Observations
<input type="checkbox"/> 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:** \_\_\_\_\_