Arlington Heights School District 25

1200 S. Dunton, Arlington Heights, IL 60004

Authorization to Release/Exchange Confidential Information

Home School:

Attending School:

Student ID: **Date:**

Student Name:	**Date of Birth**	**Age**	**Grade**	**Gender**
Last: First: Middle:				
District Contact Person: Educational Team	**Home Phone:**		**Fax#:**	

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:	Name: Address: Phone:

The following information is requested for the purpose of .	
[☐] Psychological Reports [☐] Social Work Reports [☐] Psychiatric Reports [☐] Medical/Hospital-Records/Reports	[☐] Educational Records/Reports [☐] Most Recent Case Study Evaluation & IEP [☐] Telephone Contacts [☐] E-mail Contacts
[☐] **Other:**	

I understand that, as parent or guardian, I control access and release of student records to all individuals or agencies or school 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 my consent to release/exchange confidential information can be revoked at any time.

The consequences of not signing this release are:

Release of any mental health records by law must also be signed by the student, if between the ages of 12 and 18 years old.

Parent/Guardian Signature: ______________________________ Date: ______________

Student Signature (12 yrs. or older): ______________________________ Date: ______________

Witness Signature: ______________________________ Date: ______________

This consent is valid until this specific date: