

SPEED S.E.I.A. #802
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Chicago Heights, Illinois 60411-2491



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AUTHORIZATION FOR RELEASE OF INFORMATION

STUDENT NAME:

DATE:

I, _____, hereby authorize the exchange of records and information listed below concerning
(name of parent or guardian)

between School District No. _____ agents and employees and
(name of student)

(name of person/agency)

These disclosures are authorized by me pursuant to 20 U.S.C. Section 1232g, 34 C.F.R. Section 300.622, 105ILCS 10/1 et seq., and 740 ILCS 110/1 et seq. * and are to be made for the purpose of educational planning for _____ (name of student). I understand that I have the right to inspect and copy the information contained in those records. I also understand that my refusal to consent to the exchange of records and communications could impede educational planning for and/or service delivery to _____ (name of student).

This consent expires one year from the date indicated below. However, I understand that my consent is voluntary and that I have the right to revoke my consent in writing at any time.

The following records/information will be released (list):

PARENT/GUARDIAN SIGNATURE

DATE

STUDENT SIGNATURE

DATE

(for mental health/developmental disability records, if student is age 12 or older)

WITNESS SIGNATURE
(for mental health/developmental disability records)

DATE

NOTE: Prior to the release of protected health information, health care providers may require the parent/guardian to execute an additional authorization form to comply with the Health Insurance Portability and Accountability Act (HIPPA).