

AUTHORIZATION TO RELEASE/OBTAIN INFORMATION

Name: _____ Date of Birth: _____

Release (original on file)

I hereby authorize General McLane School District to release information to:

1 _____
Agency/Provider

_____ Address

2 _____
Agency/Provider

_____ Address

Obtain (copy on file)

I hereby authorize:

1 _____
Agency/Provider

_____ Address

2 _____
Agency/Provider

_____ Address

to release information to the General McLane School District.

Dates to be disclosed: _____

Information to be released: All educational records Special education records only
 Regular education records only Disciplinary records
 Verbal communication between school district & treatment provider

Information to be obtained: Psychiatric reports and diagnoses
 Psychological reports and diagnoses
 Medical reports and diagnoses (including any medication history treatment)
 Verbal communication with treatment provider

Purpose for release/obtain of records: to facilitate educational placement and programming.

I understand that I may revoke this consent at any time by notifying General McLane School District in writing. If you wish to revoke this authorization at any time before it expires, the school district will provide a form for you to use. I understand that I may not revoke this authorization to the extent that the school district has already relied upon it.

Date or event upon which this consent expires: _____

I have read this authorization or had it explained to me and I understand the reason for its contents.

I acknowledge that this authorization has been explained to me, if necessary through an interpreter proficient in my language.

Client/Legal Representative _____ Date _____

Witness _____ Date _____

Interpreter Signature _____

If you are the legal representative of the person listed above, please check the basis for your authority:

Parent Power of Attorney (attach copy)
 Legal Guardian (attach copy) Other