Permission to Obtain & Release Information

Dear Parent:

In order to obtain and release information regarding your child, ______ please complete and return this form. If you have any questions, my contact information is provided below.

Name & Title of Contact Person	
Phone	**Email**

I, the undersigned, hereby request and authorize:
Fremont County School District #24

To release to or obtain from:	
Agency	Phone: Fax:
Address	
Agency Contact Person	

Information Provided For:	
Name Of Child	
Date Of Birth	

Information Requested:	
☐	Official child academic/administrative records (identifying information, grade level completed, grades, class rank, attendance records, and group aptitude and achievement assessment results)
☐	Medical and/or related health records, including:
☐	Special Education confidential file (Evaluation, Eligibility & IEPs)
☐	Participation, development or implementation of the IEP and exchange of applicable agency documents.
☐	Other (specify):

Purpose of Disclosure:

This permission is valid for one year from the date signed. A copy of this form is as effective as the original.

understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent and that the ritten revocation must be given to the agency/organization I authorized to release information. I recognize that health records, once ceived by the school district or public agency, may not be protected by the HIPPA Privacy Act and may become education records otected by the Family Educational Rights and Privacy Act (FERRPA). I also understand that if I refuse to sign, such refusal will not terfere with my child's ability to obtain health care.

ignature of arent/Relationship ______________________________ **Date** ______________