Jackson Local Schools

Parent/Guardian Permission for Release of Student Information

STUDENT INFORMATION

Last Name	First Name	Middle	Birthdate

Address	City	State	Zip Code

Phone Number	School Building	Grade	School Year

DISCLOSURE

Type of communication/disclosure (check all that apply): ☐ verbal ☐ written

I authorize Jackson Local Schools to (check all that apply): ☐ ***release information to:*** ☐ ***obtain information from:***

Entity Name	Contact Name		

Address	City	State	Zip Code

Phone Number	Fax Number

INFORMATION TO BE DISCLOSED

☐ All Educational Records
☐ Academic Records/Transcript of Credits and Grades
☐ Attendance Records
☐ Test Scores
☐ 504 Plan/504 Evaluation Information
☐ Individualized Education Plan (IEP)
☐ Gifted Education Information/Plan
☐ Evaluation Team Reports/Assessments
☐ Limited English Proficiency Records

☐ All Health Records
☐ Immunization Records
☐ Continuity of Medical Care Information
☐ Lab Results
☐ Physician's Notes
☐ Consultation Reports
☐ Medication Orders
☐ Diagnostic Reports
☐ Counseling Records

☐ Other pertinent information (specify): _____

_____

PURPOSE OF DISCLOSURE

☐ to aid in making present and future educational decisions ☐ to aid in health care management at school

☐ other (specify): _____

EXPIRATION AND REVOCATION

This authorization may be revoked (cancelled) at any time except to the extent that the provider has already released personal health, education and/or other personally identifiable information prior to the revocation of this authorization. Requests for revocation must be in writing to Jackson Local Schools. If not revoked, this authorization will expire one year after the date on which the authorization is signed **OR** on this specified date: _____.

SIGNATURE

I acknowledge that this authorization is voluntary and I have received a copy of this authorization.

Signature of Parent or Guardian	Relationship to Student	Date

Signature of School Representative	Title	Date