ROCKFORD PUBLIC SCHOOLS

Students Name: _____
Date of Birth: _____

CONSENT FOR RELEASE OF INFORMATION

(USE SEARATE FORM FOR EACH CHECKED TRANSACTION)

☐ I hereby authorize Rockford School District #205 to **obtain** pertinent information concerning the above named student. (To: #205)

☐ I hereby authorize Rockford School District #205 to **release** pertinent information concerning the above named student. (From: #205)

To: _____ From: Rockford Public School Dist. #205

Attn: _____ Special Education Records

_____ Attn: Deidra Clark

_____ Phone: 815-966-5256

FAX: _____ Email: clarkd@rps205.com

FAX: 815-966-3128

For the purpose of: Special Education/School Placement

The following information may be released:

- ✓ Case Study evaluation & multidisciplinary staff conference report
- ✓ Psychological report
- ✓ Psychiatric report
- ✓ Social Work reports
- ✓ Educational Evaluation reports
- ✓ Other: _____
- ✓ Special education placement forms
- ✓ Individualized education program
- ✓ Health & physical record
- ✓ Teacher &/or counselor observations, ratings, & recommendations
- ✓ Speech & Language evaluation

I understand that this authorization allows release of records for 364 days from the date below, but I may revoke this consent at any time.

I understand that I have the right to inspect, copy, & challenge the information contained in the records received.

I certify that I am the parent or legal guardian of the above named student & have the authority to sign this release.

_____ _____

Relationship to Student: **Date:**

_____ _____

Print Name: **Signature:**