

Student Assistance Program

Release of Information

Date: _____

Student Name _____ D.O.B. _____

I hereby authorize _____ (agency/individual) to

(check one): ☐ Obtain from ☐ Release to ☐ Obtain from & Release to
_____ (agency/individual).

Address _____

Method of Release (check one): ☐ Written ☐ Written/Verbal

The information is to be shared for the purpose of facilitating the student's educational program.
The information to be released and/or obtained is (check all that apply):

- _____ Educational Records (Including Special Education documents)
- _____ Behavior Records
- _____ Counseling Records
- _____ Psychiatric Evaluation
- _____ Psychological Evaluation
- _____ Intake/Discharge Summary
- _____ Drug and Alcohol Treatment Summary
- _____ Other (please specify): _____

Please note: (Any information received by the "XYZ School District" will be placed in a file to which parents have access and the capacity to release to a third independent agency. The professional staff of the "XYZ School District" monitors this access. Information will be handled according to the "XYZ School District" Records Policy.

I may revoke this release at any time except to the extent that the person who is to make the disclosure has already acted on it. Except as noted above, this release will expire one year from now unless revoked earlier in writing. All information released or obtained will be handled confidentially in compliance with the Family Educational Rights and Privacy Act (FERPA).

Parent/Guardian Signature _____ Date _____

Student Signature _____
(14 years or older for mental health records; any age for student's own drug and alcohol records; 18 years or older for educational records)

Age _____ Date _____

Witness Signature _____ Date _____