

RELEASE OF CONFIDENTIAL INFORMATION AND RECORDS

Dowagiac Union School District, Dowagiac, Michigan

Student Name _____

Date of Request for _____

Information/Records _____

Day of Birth _____ Age _____

District/School _____

PROVIDER(S)

We are requesting the specified information and records **FROM:**

▶ Name	School/Agency
Telephone	Fax
▶ Name	School/Agency
Telephone	Fax
▶ Name	School/Agency
Telephone	Fax

PURPOSE

The information and records are requested for the following purpose: Educational programming Other (Specify)

REQUEST

Initials

Requested Information and Records

- _____ Ongoing two-way written communication:
_____ Ongoing two-way verbal communication:
_____ Most recent progress reports and notes:
_____ Current Individualized Education Program (IEP):
_____ Most recent evaluation team and diagnostic findings:
-

RECIPIENT

We are requesting the indicated information and records are **SENT TO:**

Name	School/Agency		
Address			
City	State		Zip Code
Telephone	Fax		

CONSENT

I **hereby authorize** the release of the initialed **information to the recipient listed above**. I understand that this authorization will expire one year from the date of my signature unless otherwise specified, and that this authorization may be withdrawn by me at any time without prejudice. Withdrawal of this authorization will not affect any information already released.

Signature of Consent

Date

Signed by: **Student** (Must be at least 18 years of age) **Parent** **Legal Guardian**

Signature of Witness

Date

RELEASE

The requested information and records were sent to the recipient listed above by:
Name

Sending Date

10/2012djh