DISTRICT 186
SPRINGFIELD PUBLIC SCHOOLS

AUTHORIZATION FOR RELEASE OF INFORMATION

Student Name	Date of Birth	Parent/Legal Guardian Name	Relationship

I authorize the mutual sharing of my child's highly confidential information between:

Springfield Public School District 186
Name of School/Dept: _____
Attention: _____
Address: _____
City, State, Zip: _____
Phone/Fax: _____

AND

Individual/Agency: _____
Attention: _____
Address: _____
City, State, Zip: _____
Phone/Fax: _____

TYPE OF INFORMATION TO BE RELEASED (Initial next to information to be exchanged.)

Student Initials	Guardian Initials	Type of Confidential Information
		Educational (e.g., attendance, behavior and grade reports, expulsions, special education assessments, individualized education plans, progress in meeting educational goals, educational recommendations, interventions)
		Medical (e.g., results of medical assessments, diagnoses, treatment plans, treatment progress, medication history, recommendations, summary of contacts)
		Psychiatric/Psychological (e.g., diagnoses, assessment, treatment plans, treatment progress, medication history, recommendations, summary of contacts)
		Alcohol/Drug (e.g., diagnoses, assessments, treatment plans, treatment progress, medication history, recommendations, summary of contacts)
		Child Welfare (e.g., incidents resulting in DCFS or community agency involvement, assessments, service plans, progress on service plans, placement history, court reports, recommendations, summary of contacts)
		Legal (e.g., arrests, probation history, convictions, progress on probation/parole, detention history, recommendations, summary of contacts)
		Other: (specify)

PURPOSE FOR RELEASE OF INFORMATION (Initial next to purpose for release of information.)

Student Initials	Guardian Initials	Purpose for Requesting Information
		Coordination of services with the above named individual or agency
		Consultation with the above named individual or agency
		Parent Request
		Other: (specify)

- I understand this consent is valid for one (1) year following the date signed, specifically, _____
- I understand that I may revoke this authorization in writing at any time except to the extent that action has already been taken.
- I understand that a copy or fax of this consent will be considered legal in lieu of the original document.
- I understand that I have the right to inspect and copy the information to be disclosed.
- I understand that refusal to consent may impact educational planning.

SIGNATURES (Required to authorize the mutual sharing of highly confidential information, as specified.)

X _____ _____
Parent/Legal Guardian Signature — Date

_____ _____
Student Signature (Age 12 & older) — Date

_____ _____
Witness Signature — Date