# Consent for Disclosure of Confidential Information

(USBE Rules IV.V.14.)

District/School:

Student Name: DOB: Grade:

**Authorization for the persons or agencies named below to disclose to each other confidential information regarding the student named above.**

Name and Title of School Staff Representative

Name of School

Address:

Fax #:

Representative/Agency

Name of Representative/Agency

Address:

Fax #:

**Records to be Released/Disclosed**

Independent evaluations, medical records, psychiatric evaluations

Vocational testing, English language proficiency

Other records of above-named outside agency (specify):

**Purpose of Release/Disclosure**

To assist the IEP committee in educational planning

Other (specify):

**Please mark the appropriate responses below.**

I have been fully informed in my native language or other mode of communication and understand the school’s request for my consent, as described above. This information will be disclosed upon receipt of my written consent.Yes No

I understand that my consent is voluntary and may be revoked anytime. However, I understand that revocation is not retroactive (i.e., it does not negate an action that has occurred after the consent was given and before the consent was revoked).Yes No

I give my permission for the identified records to be released/disclosed to the named persons/agencies.Yes No

Parent/Student who is an Adult Signature Date

Translator/Interpreter Signature, if used Date

**Please return this form to:**

at

School Staff Representative School

**For more information, call:**

at

School Staff Representative Telephone Number