



AUTHORIZATION FOR THE EXCHANGE OF CONFIDENTIAL INFORMATION

I, _____ (name of parent/guardian/student if 18 or greater) hereby authorize the exchange of communications and the release/exchange of the following records or confidential information and/or communications concerning _____ (hereinafter "the Student") between:

THE GLENBROOK HIGH SCHOOLS, DISTRICT #225, its agents and employees and:

NAME OF OTHER PERSON/AGENCY:

ADDRESS:

TELEPHONE

EMAIL:

These disclosures are authorized pursuant to 20 U.S.C. Section 1232g, 105 ILCS 10/1 et seq., and 740 ILCS 110/1 et seq.,* and are to be made **for the purpose of:**

- Educational evaluation and/or planning
- Facilitating linkage for transition purposes
- Other (please specify): _____

The following information will be released per the list below:

- All permanent records (such as: academic transcripts/state test scores, attendance records, health records, etc.)
- All temporary records (such as: disciplinary information, health-related information, class schedules, etc.)
- All special education records (such as: evaluation reports, IEPs, etc.)
- Other (specify): _____

I understand that I have the right to inspect and copy the records and information to be disclosed, challenge their contents, and limit my consent to designated records or portions of the information or communications contained in those records. I also understand that my refusal to consent to the exchange of records and communications could result in _____ for the Student.

This consent expires one year from the date indicated below. However, I understand that I have the right to revoke this consent in writing at any time.

PARENT/GUARDIAN SIGNATURE
(if Student is less than 18 years)

DATE

STUDENT SIGNATURE (for mental health/
developmental disability records, if student
is age 12 or older, but less than 18 years)

DATE

WITNESS SIGNATURE (for mental health/
developmental disability records)

DATE

* NOTE: Prior to the release of protected health information, health care providers may require the parent/guardian to execute an additional authorization form to comply with the Health Insurance Portability and Accountability Act (AHIPAA@).