Niles Elementary School District No. 71

6901 W. Oakton Street, Niles IL 60714-3024
PH: 847-966-9280 FAX: 847-966-1478

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

Release of Records of: _____ **Birth Date**: _____
Student Name

Information Requested By: _____ _____ _____
Requester Name Relationship to Student Date

Reason for Request:

□ Release by _____ to below named agency/person.

□ Release from below named agency/person to _____ _____.

□ Exchange of information/records between *District #71* and below named agency/person.

_____ _____ _____
Name Title Agency

_____ _____ _____
Address City, State, Zip Phone Fax

Records Requested:

□ Individual Education program (IEP): _____ □ Section 504 Plan: _____
□ Psychological Report: _____ □ Eligibility Conference Report: _____
□ Any and All Educational Records: _____ □ Health/Medical: _____
□ Other (Specify): _____

FOR OFFICE USE ONLY:
Information Delivered by: _____ □Mail □Phone □Fax □Personal Contact □Date _____

The Purpose of this Request is:

□ Transfer to/from _____ □Medical follow-up □ Educational Planning
□ Personal copy for parent/guardian □Other (Specify): _____

By signing this form I acknowledge that I have been informed of my right to:

1. Inspect and copy school records at my expense.
2. Challenge the contents of school records
3. Limit consent to designated records or portions of records, and
4. Revoke my consent to release confidential information at any time, however my revocation does not apply to any records already released by District No. 71 and my revocation is not effective until it is received by the records custodian.

By my signature, I consent to the release of the above-described records:

x_____ _____
Signature of Requester Date of Consent

This authorization expires on (insert date or event, not to exceed one year from date of consent): _____, or will automatically expire one year from date of consent.

Records Regarding Mental Health and Developmental Disability:
If the requester seeks the release of information kept regarding the student's receipt of mental health or developmental disabilities services, please include the signature of a witness: _____.
Witness Signature

And if the student is 12 years of age or older, student must also sign for release:

x_____ _____
Signature of Student Date