



## Authorization to Release School Records/ Exchange Information

\_\_\_\_\_ authorizes the release of the school records/exchange of  
(Name of Parent/Guardian or student 18 years or older) information for:

Last Name of Student	First Name	Middle Name/Initial	Date of Birth
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<b>FROM/TO:</b> (circle one or both)	_____ Highland Park High School 433 Vine Avenue Highland Park, IL 60035 Phone: 224-765-2200 FAX: 224-765-2708	_____ Deerfield High School 1959 N. Waukegan Road Deerfield, IL 60015 Phone: 224-632-3200 FAX: 224-632-3206	
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### FROM/TO:

Medical Provider

**Name**

\_\_\_\_\_

**Address**

\_\_\_\_\_

**Phone**

\_\_\_\_\_

**Fax**

\_\_\_\_\_

**E-Mail**

\_\_\_\_\_

My signature authorizes the release/exchange of the following records/information:

- \_\_\_\_\_ Transcript of subjects, grades & test records, & other school progress reports
- \_\_\_\_\_ Attendance Records
- \_\_\_\_\_ Discipline records (including suspensions & expulsions)
- \_\_\_\_\_ Immunization records and medical provider statement of immunity with justification for their medical opinion
- \_\_\_\_\_ Medication information
- \_\_\_\_\_ IEP (Individual Education Program); Goal updates; Progress reports
- \_\_\_\_\_ Social Developmental Study
- \_\_\_\_\_ Psychological, Educational, other diagnostic information
- \_\_\_\_\_ Other related/support service (i.e.: Counseling, Psych, Soc. Work, SLP, OT, PT, etc...) evaluations/progress
- \_\_\_\_\_ Psychiatric, neurological, other medical evaluations or running records
- \_\_\_\_\_ Exchange information through e-mail correspondence or conversation
- \_\_\_\_\_ Purpose: State health department (IDPH) review of the medical provider's statement, student's immunization record, and any other supporting documents. (IL School Code 77 Section 665-280)

I understand that the information obtained will be treated in a confidential manner under the provisions of the Family Education Rights and Privacy Act (FERPA). FERPA prohibits disclosure of personally identifiable information without consent except in limited circumstances. Please note that if the request is for health or medical information, the medical information received by the district is protected under FERPA privacy standards by a school district and not the Health Insurance Portability and Accountability Act (HIPAA).

I understand that my consent is voluntary and can be withdrawn at any time in writing. Should I withdraw my consent, it does not apply to information that has already been provided under the prior consent for release. Unless withdrawn in writing, this consent will expire on: \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Student Signature (Required if student is 18 yrs. or older)

\_\_\_\_\_  
Date