SCHOOL CONSENT FOR RELEASE OF INFORMATION

Student Name: ______________________________ Birthdate: ___________________________

Address: ____

City/State/Zip code: ____

I hereby authorize the exchange of information regarding the above named student between

School Name: _________________________ & KSB Pediatrics Center @ Edwards Clinic

School Town: _________________________ 144 North Court

Dixon, IL 61021

(P) 815-285-5437 (F) 815-285-8928

Release the following records:

1. Cumulative Records including current grades, attendance and testing — Yes _X_ No ___
2. Health Records including dental, physical, immunizations and ADHD Reports & prescriptions — Yes _X_ No ___
3. Special Education Records including IEP's, evaluations, psychological, Social histories, speech/language and testing — Yes _X_ No ___
4. All prior records for school systems other than your district — Yes ___ No _X_
5. Other ____ — Yes ___ No _X_

- I certify that I am the parent or legal guardian of the above-named student & have the authority to sign this release
- I understand that this information may not be forwarded to another individual, agency or organization without my consent
- I have the right to inspect and obtain a copy of the records that have been disclosed
- I understand that my refusal to consent to the release of the above-mentioned information will prevent the disclosure of the information
- I understand that I may revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present it to my child's school
- I understand the revocation will not apply to the information that has already been released in response to this authorization
- This authorization will expire one year from the date of authorization unless otherwise revoked

____ ______________________________

Signature of Parent/Legal Guardian Date