PLAINFIELD COMMUNITY CONSOLIDATED SCHOOLS
DISTRICT 202
PLAINFIELD, ILLINOIS 60544

School Phone: School Fax:

AUTHORIZATION FOR EXCHANGE OF CONFIDENTIAL INFORMATION

Name of Child: ______________________ Birth Date: ______________

Home Address: ______________________ Home Phone: ______________

School: ______________________ Contact Person: ______________

I hereby grant permission to Plainfield District 202 to release/exchange confidential information concerning:

(Name of Student) ______________________

(Name of Agency) ______________________

I understand that my permission covers possible discussions between the above agencies, the release/exchange of permanent and temporary records, as well as the release/exchange of mental health records, confidential records and reports including the following, as available:

- ☐ Results of standardized achievement tests
- ☐ Results of interest and aptitude inventories
- ☐ Teacher reports and observation
- ☐ Health Information
- ☐ Discipline and behavior records, reports and inventories
- ☐ Transcript of courses taken and grade earned
- ☐ Special education files, including Individual Educational Program and Multidisciplinary Staff Conference Reports
- ☐ Psychological Reports
- ☐ Neurological Reports
- ☐ Psychiatric Reports
- ☐ Social Work Reports and observations
- ☐ Other

Reason for release of records: ______________________

This information will not be used for any other purpose than stated above.

I understand that I have the right to inspect and copy school records, to challenge the contents of these records and/or limit this consent to specific records and portions of records which I have designated as follows: ______________________

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I understand that there may be consequences with a refusal to consent to release of any of the above information, in that such might impede educational planning.

This authorization terminates at the end of the current academic school year but can be revoked at any time via written notice to either of the above agencies.

Date ______________________

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Signature of Parent/Guardian or Adult Student over 18 years of age
(Note: If mental health records are to be released, student must sign along with parent, if student is between the ages of 12 and 17, inclusively)

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Relationship