ROCKFORD PUBLIC SCHOOLS

Students Name: _____

Date of Birth: _____

CONSENT FOR RELEASE OF INFORMATION

(USE SEPARATE FORM FOR EACH CHECKED TRANSACTION)

☐ I hereby authorize Rockford School District #205 to **obtain** pertinent information concerning the above named student. (To: #205)

☐ I hereby authorize Rockford School District #205 to **release** pertinent information concerning the above named student. (From: #205)

To: _____

Attn: _____

_____

_____

FAX: _____

From: Rockford Public School Dist. #205

Special Education Records

Attn: Kaliyah Turner

Phone: 815-966-5256

Email: kaliyah.turner@rps205.com

FAX: 815-966-3128

For the purpose of: Special Education/School Placement

The following information may be released:

- ✓ Case Study evaluation & multidisciplinary staff conference report
- ✓ Psychological report
- ✓ Psychiatric report
- ✓ Social Work reports
- ✓ Educational Evaluation reports
- ✓ Other: _____
- ✓ Special education placement forms
- ✓ Individualized education program
- ✓ Health & physical record
- ✓ Teacher &/or counselor observations, ratings, & recommendations
- ✓ Speech & Language evaluation

I understand that this authorization allows release of records for 364 days from the date below, but I may revoke this consent at any time.

I understand that I have the right to inspect, copy, & challenge the information contained in the records received.

I certify that I am the parent or legal guardian of the above named student & have the authority to sign this release.

_____ **Print Name:**

_____ **Signature:**

_____ **Relationship to Student:**

_____ **Date:**

WC 8/9/23