

AUTHORIZATION FOR RELEASE OF RECORDS

Student name: _____ Date: _____

Student DOB: _____ School District: Cape Flattery School District

I hereby authorize the release of records:

From: _____ To: _____
(Name of agency/person) (Name of agency/person)

Street Address Street Address

City, State, Zip City, State, Zip

Describe the records to be disclosed:

Transcript	Special Education Records	Other:
Most Recent Grade Report	Most Recent IEP	
Immunizations	Most Recent Evaluation	
Discipline Reports	Psychological Evals/ Testing	
Most Recent State Test Scores	OT/PT/ SLP Reports	
State Identifier Number (SSID)		

The reason for disclosing the record(s) is:

I understand that this information obtained will be treated in a confidential manner by the school district 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 and not the Health Insurance Portability and Accountability Act (HIPAA).

This authorization is valid from: _____ to _____ .
Date Date

Note: For release of medical records, the authorization can be no longer than 90 days after this authorization is signed.

I understand that my consent for the release of records is voluntary and I can withdraw my consent 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.

Parent/guardian/adult student Signature Date