

THE SCHOOL BOARD OF BROWARD COUNTY, FLORIDA

AUTHORIZATION FOR RELEASE AND/OR REQUEST FOR INFORMATION

I hereby request and authorize: (Name of Person, School, or Department) to engage (Street Address) (City) (State) (Zip) (Telephone #)

in verbal and/or written communication with and release records to: (Name of Person, Job Title and/or School/Agency/Entity) (Street Address) (City) (State) (Zip) (Telephone #)

regarding the information checked below concerning my child* , whose date of birth is . I understand that information concerning psychiatric, psychological, medical diagnosis, drug or alcohol abuse, economic status, and educational information regarding my child will be released and/or communicated if indicated below. I further understand that this information might contain information regarding my family, in addition to my child.

- Treatment Plans
Treatment / Discharge Summaries
Health / Medical Records
Case / Progress / Therapy Notes
Academic / School-related Records:
Grades
Test Scores
Attendance
Suspensions / Expulsions
Exceptional Student Education / Section 504 records
Other
Substance Abuse Treatment Records
Social and/or Developmental History
Psychological and/or Psychiatric Evaluations
Restorative Support Services
Social Support Services (Food, Clothing, Shelter)
Medical Services
HIV/AIDS test results or related conditions (to disclose or receive this information, specific individuals must be named above)

For the Purpose of:

I acknowledge that all information I authorize to be released or requested will be held strictly confidential and cannot be released by the recipient without an additional written consent. I understand this authorization will expire one (1) year after the date signed, or on , 20, whichever is earlier. A copy of this authorization is valid in lieu of the original. I further understand I may withdraw my consent in writing at any time.

Print Name of Parent / Guardian / Eligible Student Signature of Parent / Guardian / Eligible Student Date

Relationship to Child

*Eligible students (age 18 or over) may authorize the release of their education records.

(USE THIS SPACE IF CONSENT IS WITHDRAWN)

I hereby withdraw my previous consent to the release of information about my child.

Date Consent Is Withdrawn Signature of Parent / Guardian / Eligible Student