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
____ Student Identification Number

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(USE THIS SPACE IF CONSENT IS WITHDRAWN)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Date Consent Is Withdrawn Signature of Parent / Guardian / Eligible Student