COMMUNITY CONSOLIDATED SCHOOL DISTRICT 59
1001 Leicester Road * Elk Grove Village, IL 60007
PH: 847-593-4300 * FAX: 847-593-4352

AUTHORIZATION FOR EXCHANGE OF CONFIDENTIAL INFORMATION/RECORDS

Student ______________________________ Birth Date ____________________

Parent's Name(s) ______________________________ Student ID # ______________

Home Address ____

City ______________________________________ Zip Code ________________

Last School of Attendance (*Dist.59*) ____

Last Year of Attendance (*Dist.59*) ____

I/we hereby authorize that the following information will be released/exchanged:

▫ All permanent records (including, but not limited to, basic identifying information, birth certificate or other proof of student's identity, academic transcript, attendance records, and health records, where applicable.

▫ All temporary records (including, but not limited to, scores on State assessments administered in grades K-8, discipline records, health-related information, accident reports, family background information, psychological evaluation reports, aptitude and achievement test results, report cards, honors and awards, progress monitoring information, IDEA/special education records, and Section 504 records)

These disclosures are authorized pursuant to the *Family Education Rights and Privacy Act* (20 U.S.C. Section 1232g), the *Illinois School Student Records Act* (105 ILCS 10/1 *et seq.*), and the *Illinois Mental Health and Developmental Disabilities Confidentiality Act* (740 ILCS 110/1 *et seq.*),* and are to be made for the purpose of:

▫ Educational evaluation and/or planning ▫ Other [specify]:

*Prior to the release of protected health information, health care providers may require the parent/guardian to execute an additional authorization form to comply with the *Health Insurance Portability and Accountability Act* ("HIPAA").

I understand that I have the right to inspect and copy the information to be disclosed, challenge its contents, and limit my consent to designated records or portions of the information contained in those records. I also understand that my refusal to consent to the exchange of records and communications could result in incomplete and/or inappropriate educational planning for the student. This consent expires one year from the date indicated below. However, I understand that I have the right to revoke this consent in writing at any time.

▫ I authorize District 59 to release information concerning the above named student.

▫ I authorize District 59 to obtain information concerning the above named student.

TO: ______________________________ FROM: ______________________________

______________________________ ______________________________

Phone: ______________________________ Phone: ______________________________

For the purpose of:

Check those applicable: ▫ Student Records ▫ Other

Printed Name ______________________________ **Signature**______________________________
Date______________ ***[If under the age of 18, parent signature is required]***

Witness Signature[*required for mental health/developmental disability records*]______________________________
Date______________

Student Signature [*required for mental health/developmental disability records*] ______________________________
Date______________**(if the student is age 12 or older)**