NEW TRIER HIGH SCHOOL

# AUTHORIZATION FOR RELEASE OF INFORMATION

**Full Student Name:**

**Date of Birth:**

**Phone Number:**

**Complete Student Address:**

☐ **To** ☐ **From**

**New Trier High School District**

☐ **To** ☐ **From**

**Name:**

**School/Organization Address:**

**Phone:**

**Fax:**

**Email:**

**Phone:**

**Fax:**

**Email:**

**Records and Information to be released:**

- ☐ Attendance
- ☐ Trascripts/Grades
- ☐ 504 Records
- ☐ Special Ed. Records (IEPs, Evaluations, Progress Reports)
- ☐ Email & other written documentation
- ☐ Verbal communication & conversation
- ☐ Other:
- ☐ Disciplinary Reports
- ☐ Psychological Evaluations
- ☐ Achievement Test Scores
- ☐ Health/Mental Records

**The purpose of this release of information is:**

I authorize the release of student records and confidential information concerning the student listed above. I understand that I have the right to inspect, copy, and challenge the content of the school student records for which I am authorizing release. I also have the right to designate the school student records or specific portions of a school record to be released by this consent. The consequence of failure to consent to release is that records will not be released. This authorization is valid until , unless I revoke consent prior to that time. The information released cannot be redisclosed or utilized for any purpose other than as specified above.

**Parent/Guardian Signature**
(if student is under 18)

**Date**

**Student Signature**
(if at least 18, or at least 12 and mental health records are to be exchanged)

**Date**

**Witness Signature**
(if mental health records are to be exchanged)

**Date**

**Reset** **Print**