NEW PRAGUE AREA SCHOOLS
CONSENT TO RELEASE PRIVATE DATA

Student Name:_____

School: _____Grade: _____Birthdate: _____

Parent Name: _____Phone : _____-_____-_____

Parent Address_____

I authorize _____ on behalf of Independent School District # 721
School District Contact Person

_____ _____ _____
School Address City, State Zip

☐ **To release information *to*:**

☐ **To obtain information *from*:** (*Check either or both boxes as needed.*)

_____
Name (On behalf of School or Organization Listed Below) Title

_____/_____/_____
Organization or School Name Telephone # Fax #

_____
Address City State Zip

Please release the following information:

☐ Official school records (name, address, birthdate, sex, attendance record, grade level, grades, Class rank, standardized group test results)

☐ Health Record

☐ Psychological Reports

☐ Special Education Records

☐ Teacher, Counselor and Staff Observations

☐ Chemical Abuse / Dependency Report

☐ Medical Report

☐ Psychiatric Report

☐ Social Work Report

☐ Other (*specify)*_____

The purpose of the request: _____

I understand that this authorization takes effect the day that I sign it, and expires no more than one year from the date of my signature. I also understand that I may change this authorization at any time. School records may be examined by parent(s), legal guardian(s), or student if student is age 18 or older. Upon receipt of records directly related to a student, the information becomes part of the student's educational record when maintained by the school district and may be disclosed pursuant to the Family Educational Rights and Privacy Act. (See 34 C.F.R Part 99) By signing below, I authorize representatives of both agencies noted above to share information related to the purpose of this request.

X_____ _____
Parent Signature or Student age 18 or older Date