| THE SCHOOL DISTRICT OF ESCAMBIA COUNTY<br>Exceptional Student Education<br>30 East Texar Drive, Pensacola, FL 32503<br>Phone: (850) 469-5518 | AUTHORIZATION FOR RELEASE OF INFORMATION |
|---|---|

**Name:**_____ **Date of Birth:**_____ **Grade:**_____

**Phone:**_____ **Address:**_____

**School:**_____ **Student #:**_____

| RELEASE RECORDS FROM: | DISCLOSE RECORDS TO: |
|---|---|
| **Facility or Name:**_____ | **Facility or Name:**_____ |
| **Address:**_____ | **Address:**_____ |
| **City/ST/ZIP:**_____ | **City/ST/ZIP:**_____ |
| **Phone:**_____ **Fax:**_____ | **Phone:**_____ **Fax:**_____ |

**I am requesting records for the dates: From:**_____ **To:** _____ ☐ **ALL Records**

**I hearby authorize these agencies to reciprocally communicate and/or release the following documents:**

| | |
|---|---|
| ☐ **Medical & Social History**<br>☐ **Psychiatric Diagnosis**<br>☐ **Psychological/Intellectual Evaluation Report**<br>☐ **Individual Education Plan (IEP)/(EP)/(SP)**<br>☐ **Placement Committee Meeting Minutes**<br>☐ **Multidisciplinary Team Report**<br>☐ **Evidence of Consent for ESE Placement**<br>☐ **Eligibility Report**<br>☐ **Adaptive Behavior Measure**<br>☐ **Re-evaluation Report**<br>☐ **Speech and/or Language Evaluation Report**<br>☐ **Rating Scale Of Gifted Characteristics**<br>☐ **Other:**_____ | **Your initials are required to release the following:**<br><br>_____ **Psychiatric/Psychology Notes**<br><br>_____ **Psychological Evaluation & Results**<br><br>**Please Note: Some of these items may require signature of the minor** |

| PURPOSE OF DISCLOSURE *(please specify)*: | EXPIRATION DATE OR EVENT: |
|---|---|
| Educational Placement/Services<br>Other: _____ | *(if left blank, this Authorization expires 1 year from the date signed)*<br>Specify a date or event:_____ |

## Authorization:

1. I may revoke this authorization at any time by notifying the "Sent FROM" organization noted above in writing.
2. I understand that my revocation does not affect any disclosures made prior to the revocation being received and processed.
3. I understand the information disclosed may be subject to re-disclosure and no longer be protected by federal or state privacy regulations.
4. I have the right to inspect or copy the information to be used/disclosed as permitted by federal law.
5. I may refuse to sign this authorization and understand that it is strictly voluntary.
6. If I do not sign this form, my health care and the payment for my health care will not be affected.
7. If this authorization originated with the provider, I will receive a copy of this form after I sign it.

**This information will be kept in the student's confidential file and will be made available only to authorized personnel.**

_____ _____

**Parent/Guardian Signature** **(Date)** **Date Sent**

**Distribution: Central Files; Cum Folder**
**9300-ESE-031 Revised: 10/09/11**