THE SCHOOL DISTRICT OF ESCAMBIA COUNTY Exceptional Student Education 40 East Texar Drive, Pensacola, FL 32503 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** ☐ **Psychiatric Diagnosis** ☐ **Psychological/Intellectual Evaluation Report** ☐ **Individual Education Plan (IEP)/(EP)/(SP)** ☐ **Placement Committee Meeting Minutes** ☐ **Multidisciplinary Team Report** ☐ **Evidence of Consent for ESE Placement** ☐ **Eligibility Report** ☐ **Adaptive Behavior Measure** ☐ **Re-evaluation Report** ☐ **Speech and/or Language Evaluation Report** ☐ **Rating Scale Of Gifted Characteristics** ☐ **Other:**_____	**Your initials are required to release the following:** _____ **Psychiatric/Psychology Notes** _____ **Psychological Evaluation & Results** **Please Note: Some of these items may require signature of the minor**

PURPOSE OF DISCLOSURE *(please specify)*:	EXPIRATION DATE OR EVENT:
Educational Placement/Services Other: _____	*(if left blank, this Authorization expires 1 year from the date signed)* 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
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