DATE FAXED: ____/____/_____

PERMISSION TO OBTAIN/RELEASE INFORMATION

SECTION I: STUDENT INFORMATION

This form provides authorization to release and/or obtain educational records and information relating to:

STUDENT NAME: _____ **DOB:** ____/____/____

ADDRESS: _____ **PHONE:** (____) _____

Street City State/Zip

SECTION II: INDIVIDUAL/AGENCY INFORMATION

I, the undersigned, give my permission to:

NAME(S) _____

SCHOOL NAME: _____ **PHONE:** _____

ADDRESS: _____ **FAX:** _____

Street City State/Zip

to obtain/release (circle) to:

NAME(S): _____

AGENCY: _____ **PHONE:** _____

ADDRESS: _____ **FAX:** _____

Street City State/Zip

SECTION III: DESCRIPTION OF EDUCATIONAL RECORDS REQUESTED AND/OR TO BE DISCLOSED

- ☐ Academic records/Transcripts of credits and grades
- ☐ Medical and/or health records
- ☐ Psychological evaluations or social work reports
- ☐ Individualized Education Program (IEP) team evaluations and related reports
- ☐ Appropriate agency reports
- ☐ Individualized Education Program
- ☐ Discipline records and expulsion proceedings
- ☐ Verbal Communication
- ☐ Other (specify): _____

SECTION IV: PURPOSE OF AUTHORIZATION

This information is being requested for the purpose of: _____

SECTION V: EXPIRATION AND REVOCATION

This authorization may be revoked (canceled) at any time except to the extent that the District has already released personal information prior to the revocation of this authorization. Requests for revocation must be in writing. To revoke the authorization, contact the Little Chute Pupil Services Department at 325 Meulemans St., Little Chute, WI 54140. If not revoked, this authorization will expire one year after the date on which the authorization is signed.

DATE FAXED: ____/____/_____

SECTION VI: SIGNATURE AND ACKNOWLEGEMENT:

I acknowledge that this authorization is voluntary and that I may request a copy of this document.

SIGNATURE REQUIRED:

		____/____/____
PARENT/GUARDIAN/STUDENT IF 18	**RELATIONSHIP TO STUDENT**	**DATE**