



# Educational Service Unit #1

*"Providing Innovation, Leadership and Service"*

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Dr. Bob Uhing, Administrator



SERVING: CEDAR • DAKOTA • DIXON • KNOX • THURSTON • WAYNE COUNTIES

## AUTHORIZATION FOR RELEASE OF INFORMATION

Date \_\_\_\_\_ Student's Name \_\_\_\_\_

DOB \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_

This Individual Authorizes: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

To Disclose to: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

The following information (i.e., records, describe nature of information from any physician, hospital, school, clinic, agency or institution having medical, psychological, school or social records):

\_\_\_\_\_

I understand that my records are protected under the Federal Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it (i.e. probation, parole, etc.)

List any special condition or qualification of this consent form: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Parent/Guarian or Authorized Representative

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
School Official Signature

\_\_\_\_\_  
Title