

School District of Greenwood

CONSENT FOR EXCHANGE OR RELEASE OF STUDENT INFORMATION

I hereby authorize the use or disclosure of the individually identifiable educational information described below for the named student.

Student Name: _____ DOB: _____

ORGANIZATION AUTHORIZED TO RELEASE INFORMATION:

School District of Greenwood | 306 W Central Avenue | PO Box 310 | Greenwood, WI 54437

PERSONS/ORGANIZATIONS AUTHORIZED TO RECEIVE INFORMATION:

Name: _____

Address: _____

City | State | Zip: _____

Phone Number: _____ Email Address: _____

SPECIFIC INFORMATION AUTHORIZED TO BE RELEASED:

Multiple horizontal lines for entering specific information.

Any information disclosed will not be released by the above-named person(s)/organization(s) to any other person(s)/organization(s) unless I so authorize. This authorization will remain in effect for 180 days from the date signed below. However, I understand that I have the right to revoke this authorization, in writing, at any time, and that the revocation will be effective except to the extent that the providing person(s)/organization(s) set forth above have taken action in reliance on this authorization before receiving the written revocation. I understand I have a right to receive a copy of this Consent for Release of Information.

SIGNATURE OF PARENT/LEGAL GUARDIAN (Student if 18 years old or older)

DATE

OFFICE:

Received Date: _____

Processed Date: _____

Processed by: _____