

# Spring Grove Elementary

2018 Main St. Spring Grove, IL 60081  
Phone: 815-678-6750 Fax: 815-678-6760

## Authorization for Exchange of Confidential Information

School Year:

Last Name:		First:		Middle:	Student ID Number	Date Of Birth
Street:						
City:	State:	Zip:	Phone:			
Parent Address:				Medicaid #:		Home: Work:
School:		Case Manager:			Gender:	Grade:

As the parent of legal Guardian of the above named child, I hereby grant my permission to Nippersink School District 2 to release/receive confidential information concerning my child to/from:

The purpose of this authorization is:

I understand that my permission covers the release of permanent and temporary record, as well as the release of confidential record and reports. I also understand that I have the right to inspect and copy school records, to challenge the contents of these records and/or limit this consent to specific records or portions of records which I have designated below:

☐ Psychological Evaluation

☐ Medical Records

☐ Psychiatric Evaluation

☐ Speech/Language Reports

☐ Health Records

☐ Individualized Education Program (IEP)

☐ Social Development Study/Records

☐ Other:

This authorization is good for 1 calendar year.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian or Adult Student over age 18

Disposition of records:

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name/Title