ARLINGTON Public Schools

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Reset Form

Authorization for the Release of Records/Information

Student | Birthdate

School | Grade

PURPOSE OF AUTHORIZATION FOR RELEASE OF RECORDS: As a parent or guardian you have the right to give permission or not give permission for the exchange of your child's records with other persons or agencies. This request provides you with the opportunity to approve or not approve such a request unless release of records is allowed under one of the exceptions under the rules implementing the Federal Family Education Rights and Privacy Act (for example, transfer of records from one school district to another).

I herby authorize the mutual exchange of confidential information and the release of records among and between the Arlington Public Schools and the person(s) or agency listed below:

To/From (Agency Name or Person)

Name

Address

City | State | Zip Code

Phone/Fax Number

To/From (District employee/title/school/department)

Name

Address

City | State | Zip Code

Phone/Fax Number

Check all records types to be released:

☐ Health/Medical Records ☐ Psychological and Counseling Records ☐ Special Education Records ☐ Transcripts

☐ Other (Specify)

The reason for disclosing the record(s) is:

I understand that the information obtained by the Arlington Public Schools will be treated in a confidential manner under the provisions of the Family Education Right and Privacy Act (FERPA). FERPA prohibits disclosure of personally identifiable information without consent except in limited circumstances. Please note that if the request is for health or medical information, the medical information received by the District is protected under FERPA privacy standards and not the Health Insurance Portability Act (HIPAA).

Note: For the release of medical records, the authorization will automatically expire 90 days from the date of signing.

I understand that my consent for the release of records is voluntary, and I can withdraw my consent at any time in writing. Should I withdraw my consent, it does not apply to information that has already been provided under the prior consent for release.

Parent/Guardian Signature *****Original signature required! Please print and sign.***** *(This notation will not print.)* | Date

Street Address | City, State, Zip