Tredyffrin/Easttown School District
Administrative Offices
940 W. Valley Road, Suite 1700
Wayne, PA 19087

STUDENT RECORD RELEASE
PARENT PERMISSION FORM

DATE: GRADE:

STUDENT:

DATE OF BIRTH:

SCHOOL:

I,_____ hereby authorize the Tredyffrin/Easttown School District, through the Department of Individualized Student Services to obtain from, release to and communicate with:

Name/Title/Agency_____
Address_____
Telephone_____

Name/Title/Agency_____
Address_____
Telephone_____

Check one:

_____ Information forwarded from my student's records will include those items specifically checked below:
_____ Information requested from the above professional/agency will include those items specifically checked below:

_____ Complete Special Education Records: Evaluation Reports, Specialist reports, IEPs, NOREPs
_____ Psychiatric Evaluations, Social Worker Reports support information
_____ Medical History/Evaluation
_____ Discharge Summary
_____ Attendance and health records

_____ School reports, academic and discipline records, transcripts, standardized test data, instructional support intervention
_____ Verbal/written communication, psychologist counselor, teacher, nurse, principal, other
_____ Other

This consent will begin the date of this authorization and will expire one year later, on _____unless revoked by me in the interim. I, the undersigned, hereby acknowledge that I have read this authorization prior to its execution and fully understand the nature of this release. All information released will be handled confidentially and in compliance with federal and state regulations.

_____ Date

_____ Parent Signature

_____ Parent Signature

THIS INFORMATION IS FROM RECORDS WHOSE CONFIDENTIALITY IS PROTECTED BY LAW. DUPLICATION WITHOUT WRITTEN CONSENT OF THE PARENT/GUARDIAN AND STUDENT (IF NEEDED) IS PROHIBITED.