Consent for Release of Confidential Info (T)

Student Name: _____ **Grade:** _____ **Date:** _____ **DOB:** _____

Information Requested By

Name: _____ **Relationship to Student/Title:** _____ **Date:** _____

Name: _____ **Relationship to Student/Title:** _____ **Date:** _____

Reason for Request

☐ Release by BASSC: Belleville Area Special Services Cooperative to below named agency/person
☐ Release from below named agency/person to BASSC: Belleville Area Special Services Cooperative
☐ Exchange of information/records between BASSC: Belleville Area Special Services Cooperative and below named agency/person

Name: _____ **Title:** _____ **Agency:** _____ **Phone:** _____

Address: _____ **City, State, Zip:** _____ **Fax:** _____

Records/Information Requested

	For Office Use Only Sent By	Date
☐ Individual Education Program (IEP) Date(s): _____		
☐ Eligibility Determination Conference Report (Previously MDC) Dates(s): _____		
☐ Psychological Report(s) Date(s): _____		
☐ Other (Specify): _____		
☐ Other (Specify): _____		
☐ Other (Specify): _____		

Information Delivered By: ☐ Mail ☐ Phone ☐ Fax ☐ Personal Contact ☐ Date: _____

The Purpose Of This Request Is

☐ Transfer to/from BASSC: Belleville Area Special Services Cooperative
☐ Information for another agency
☐ Personal copy for parent/guardian
☐ Medical follow-up
☐ Educational Planning
☐ Other (Specify) _____

Your signature confirms you have been informed of your right to

1. Inspect and copy school records at your expense
2. Challenge the contents of school records, and
3. Limit consent to designated records or portions of records

This consent will automatically expire (1) year after the date of the signature.

By my signature, I consent to the release of the above described records

X _____
Signature Date of Consent

Relationship to Student: ☐ Parent ☐ Guardian ☐ Student of Majority Age ☐ Other (Specify): _____

If seeking records from a mental health agency and student is 12 years of age or older, student must also sign for release

X _____
Student Date