

Bartholomew Consolidated School Corporation
Consent for Release of Education Records
AUTHORIZATION FOR USE AND/OR DISCLOSURE OF EDUCATION RECORDS

The Family Educational Rights and Privacy Act (FERPA) is a federal law that protects the privacy of student education records created or maintained by a school that receives federal funds. Completion of this document authorizes the disclosure and use of education records as described below. Completion also authorizes you to discuss this information with representatives of the organization named below entitled to receive said information.

STUDENT INFORMATION:

Student Name: _____ Date of Birth: _____
Social Security Number: _____ Grade: _____
School: _____
Parent/Legal Guardian Name: _____
Relationship to Student: _____

USE AND DISCLOSURE INFORMATION:

I, the undersigned, do hereby authorize _____
(name of agency or educational institution maintaining records)
to disclose and deliver the following checked education records maintained under the above student's name:
 All records. Otherwise, please check the appropriate boxes for release.
 Grades and transcripts Psychological testing & evaluations Verbal Information
 School health records Special education records Discipline records
 Attendance records Standardized test scores IEP
 Social work assessment Education evaluation and reports Other: _____

**Please list any records you do not wish to be disclosed: _____
****Mental Health Records** obtained pursuant to Indiana Code 16-39-4-2 ARE NOT SUBJECT TO DISCLOSURE.

The education records described above shall be delivered to:
Name: _____ Organization: _____
Address: _____
City/State/Zip Code: _____ Telephone Number: _____

PURPOSE:

This information is to be disclosed and used for the purpose of:
 Special Education Evaluation & Planning § 504 Evaluation & Planning
 Provision of Special Education Services Information for School Nursing
 Other _____ (please provide explanation).

AUTHORIZATION FOR REDISCLOSURE:

Under federal law, the requestor (School District) may not redisclose the information identified above to any other party without your prior consent. If you wish to authorize the School District to redisclose the information identified above please mark the box below:
 I authorize the School District to redisclose the education information described above and I understand that if the information is redisclosed it may not be protected by federal privileges, privacy laws or regulations.

APPROVAL:

My authorization for the use, disclosure and/or redisclosure of the information identified above is voluntary. I understand that the information to be disclosed or redisclosed may include individually identifiable health information. I understand that, upon my request, I am entitled to a signed copy of this authorization form and the records to be disclosed. Unless sooner terminated in writing, this release shall remain effective for **1 year** from the date signed below. A copy of this release shall be as sufficient to authorize release of information identified above as the original signed by me.

Signature of Student's Parent or
Student's Legal Guardian
Date: _____
Relationship: _____