PLEASE FORWARD THIS REQUEST TO ALL AGENCIES WITH RECORDS OF THIS STUDENT

Ogle County Educational Coop
417 N. Colfax PO Box 582
Byron, IL 61010
Telephone Number (815) 234-2722
Fax Number (815) 234-2938

Amboy Central School
30 E. Provost Street
Amboy, IL 61310
Telephone Number (815) 857-3619
Fax Number (815) 857-9024

Amboy Community Unit School District #272

AUTHORIZATION FOR RELEASE OF INFORMATION

DATE ___________________

STUDENT'S NAME ____BIRTHDATE ______________

SEND TO: **REGISTRAR**
AMBOY CENTRAL SCHOOL
30 E. Provost Street
Amboy, IL 61310

FROM: ____________________________________

____

____

THE FOLLOWING INFORMATION MAY BE RELEASED:

____ case study evaluation and multidisciplinary staff conference report

____ psychological report

____ psychiatric report

____ social work report

____ family background data

____ medical reports

____ individualized education program

____ health and physical record

____ official student academic record (student permanent record)

____ teacher and/or counselor observations, rating, and recommendations

____ speech/language evaluation

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~ I understand that this information may not be forwarded to another individual, agency, or organization without my written consent.
~ I understand that I have the right to inspect, copy, and challenge the information contained in the records received.
~ I certify that I am the parent or legal guardian and have the custody and control of the above named student and have the authority to sign this release.

____ _________________________ ___________
Signature of Parent/Guardian **Relationship to Student** **Date**

Please note: *Under the provisions of the Privacy Rights of Parents and Students Act, page 1213, subpart D, 99.30 (b), it is not necessary to have the written consent of the parents to release records "to official of other schools or school systems in which the student seeks or intends to enroll."*