

Mid-Valley Special Education Cooperative

Serving children and families of the Batavia, St. Charles, Geneva, Kaneland and Central Community School Districts
1304 Ronzheimer Avenue, St. Charles, IL 60174 (331) 228-4873 fax (331) 228-4874

RELEASE OF INFORMATION (PARENT)

Name of Child _____ D.O.B. _____ Date _____

Address _____

As the parent or legal guardian of the above named child, I hereby grant permission to the **Mid-Valley Special Education Cooperative** to exchange confidential information concerning my child with:

(name of agency, school district, physician, individual, etc.)

The purpose of this authorization is: assessment, evaluation, and educational planning

Other: _____

I understand that my permission covers the release of permanent and temporary records as well as the release of confidential records and reports from _____

(name of agency, school district, individual, etc.)

to **Mid-Valley Special Education Cooperative**.

Check the items listed below that you DO NOT WANT SENT, otherwise, the entire record will be forwarded.

<input type="checkbox"/> Social History	<input type="checkbox"/> Medical Eval. /Records	<input type="checkbox"/> Psychological Evaluations
<input type="checkbox"/> Achievement Testing	<input type="checkbox"/> Social Work Reports	<input type="checkbox"/> Cumulative Folder/Permanent Record
<input type="checkbox"/> Anecdotal Records	<input type="checkbox"/> Disciplinary Information	<input type="checkbox"/> Multidisciplinary Staff Conference
<input type="checkbox"/> Verified Information from Non-Educational Agencies	<input type="checkbox"/> OT/PT Therapy Reports	
<input type="checkbox"/> Proof of Guardianship		

I understand that I have the right to inspect, copy, or to challenge the contents of the records prior to the records being forwarded.

This authorization terminates 365 calendar days from the date of permission.

Date

Signature of Student over age of 12

Date

Signature of Parent/Guardian

Address

Phone