FOX CHAPEL AREA SCHOOL DISTRICT

RE: _____
D.O.B.: _____

I, _____ hereby authorize _____
(Name of Student or Guardian) _____
_____
(School Personnel)

to obtain from/release to, and communicate with _____
_____
_____
(Agency Name/Address/Phone Number)

regarding information from _____ records, including:
(Name of Student)

_____Treatment Summary

_____Treatment Recommendations

_____Diagnosis

_____Discharge Summary

_____Treatment/Aftercare Plan

_____School records including school Reports, standardized test data, behavioral information, Evaluation Reports (ER), and Individual Education Plans (IEP)

_____Phone Contact

_____Other_____

for the purpose of _____.
This consent will begin the date of this authorization and will expire one year later, on _____, unless revoked by me in writing. 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 in compliance with the Family Educational Rights and Privacy Act (FERPA).

_____
Signature of Student (If student is over 14 years of age)

_____
Signature of Witness

_____
Signature of Parent/Guardian

_____
Date

I, _____, do not authorize _____
(Name of Student or Guardian) (School Name/Address/Phone Number)

_____ to obtain from/release to, and communicate with any

agency/physician/mental health personnel at this time regarding _____.
(Name of Student)