



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 | _____ School records including school Reports, standardized test data, behavioral information, Evaluation Reports (ER), and Individual Education Plans (IEP) |
| _____ Treatment Recommendations | |
| _____ Diagnosis | |
| _____ Discharge Summary | _____ Phone Contact |
| _____ Treatment/Aftercare Plan | _____ 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 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)