Halifax County Schools
9525 Highway 301 South
Halifax, NC 27839
252-583-5111

AUTHORIZATION FOR RELEASE AND/OR REQUEST FOR INFORMATION

I hereby request and authorize:

________________________ __________________ __________ ____ _________ _________________

(Name of Person, School, or Department) (Street Address) (City) (State) (Zip) (Telephone #)

to engage in verbal and/or written communication with and release records to :(Name of Person, Job Title and/or School/Agency/Entity)

________________________ __________________ __________ ____ _________ _________________

(Name of Person, School, or Department) (Street Address) (City) (State) (Zip) (Telephone #)

regarding the **information checked below** concerning my child _______________________, whose date of birth is _______. I understand that information concerning psychiatric, psychological, medical diagnosis, drug or alcohol abuse, economic status, and educational information regarding my child will be released and/or communicated if indicated below. I further understand that this information might contain information regarding my family, in addition to my child.

Health Records:

____ Treatment Plans
____ Treatment / Discharge Summaries
____ Health / Medical Records
____ Case / Progress / Therapy Notes

Academic / School-related Records:

____ Grades
____ Test Scores
____ Attendance
____ Exceptional Student Education / Section 504 records

____ Substance Abuse Treatment Records
____ Social Support Services (Food, Clothing, Shelter)
____ Medical Services
____ HIV/AIDS test results or related conditions
____ Restorative Support Services
____ Social and/or Developmental History
____ Psychological and/or Psychiatric Evaluations
____ Suspensions / Expulsions
____ Other____________________________________

For the Purpose of: ____

I acknowledge that all information I authorize to be released or requested will be held strictly confidential and cannot be released by the recipient without an additional written consent. I understand this authorization will expire one (1) year after the date signed, or on ____________ , 20 , whichever is earlier. A copy of this authorization is valid in lieu of the original. I further understand that I may withdraw my consent in writing at any time.

______________________________ ______________________________ _____ ______________

Print Name of Parent / Guardian / Eligible Student — Signature of Parent / Guardian / Eligible Student — Date — Relationship to Child

*Eligible students (age 18 or over) may authorize the release of their education records.

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(USE THIS SPACE IF CONSENT IS WITHDRAWN)

I hereby withdraw my previous consent to the release of information about my child.

_________________ ____

Date Consent Is Withdrawn — Signature of Parent / Guardian / Eligible Student

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(FOR DOCUMENTATION PURPOSES ONLY)

Date received by school personnel: ____________ Received by: _________________________ Date records were provided: ______________________
Method of providing record: ____
List of documents/records that were provided: ____
____
Signature of person providing the record: ____
List of documents requested that are not maintained by the district: ____
Parental written confirmation of receipt of requested records: ____