**AUTHORIZATION FOR RELEASE OF INFORMATION**

**(Please print the information below)**

**I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.**

 **(parent or legal guardian) (insert name of person or entity)**

**to disclose information to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **(School’s Name)**

**Student’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I authorize the following educational, medical and/or psychological information for the following time period(s) to be released: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **(Check all that Apply):**

**Cumulative Records (including, but not limited to attendance, grades, credits, service learning**

 **hours, standardized test scores, CCR Status)**

**Confidential Records (including, but not limited to educational, related services, psychological**

 **assessments, IEPs and documents related to IEP meetings)**

**Medical and/or Mental Health Records**

**Other (pertinent information)**

**I authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_to discuss educational, medical and/or psychological information with\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (School’s Name)**

**Parent/Legal Guardian’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please fax or mail the above information to the appropriate school**

**Kent County High School H.H. Garnet Elementary School Galena Elementary School**

**25301 Lambs Meadow Rd. 320 Calvert St. 114 S. Main St.**

**Worton, MD 21678 Chestertown, MD 21620 Galena, MD 21635**

**Fax: 410-778-2714 Fax: 410-778-5707 Fax: 410-648-6881**

**Kent County Middle School Rock Hall Elementary School**

**402 Campus Avenue 21203 W. Sharp St.**

**Chestertown, MD 21620 Rock Hall, MD 21661**

**Fax: 410-778-6541 410-639-2998**

I acknowledge the notification of this transfer of records as required by the Family Educational Rights and Privacy Act of 1976 and understand that I have a right to receive a copy at my own expense, if requested, and have an opportunity for a hearing to challenge the content of the records. The staff of the Kent County Public Schools (KCPS) is pledged to maintain strict confidentiality in keeping with high ethical standards and in accordance with state and federal law, and the KCPS has procedures in place to support this policy. These procedures make it very unlikely that health information that is part of the records will be improperly disclosed. This authorization is valid for one year from the date signed, unless the authorization is revoked in writing. The revocation must contain the student’s name, name of disclosing party, name of receiving party, parent/legal guardian’s name and signature and date. I am not required to sign this authorization, and KCPS does not condition eligibility for special education or educational programming on the signing of this form.  Authorization of the release of this information may, however, assist KCPS in developing appropriate educational plans.  KCPS will not disclose any information without a signed Authorization for Release of information.