St. Lucie Public Schools
Exceptional Student Education
9461 Brandywine Lane, Port St. Lucie, FL 34986
(772) 429-4570

CONSENT FOR: RELEASE OF CONFIDENTIAL INFORMATION OR REQUEST FOR REVIEW OF STUDENT CONFIDENTIAL INFORMATION

Please release educational records for: _____, DOB: _____
(student name)

Records or consent for communication from:

Contact Person:	Phone #:
School/Office:	Fax #:
Street Address:	
City, State & Zip:	
Dates of Attendance:	

Records or consent for communication to:

Contact Person:	Phone #:
School/Office:	Fax #:
Street Address:	
City, State & Zip:	

Please include the following (check one) ☐ educational ☐ medical records:

_____

_____

_____

_____

THESE RECORDS MAY NOT BE RELEASED TO ANOTHER PARTY AND/OR AGENCY WITHOUT PRIOR APPROVAL OF THE PARENT/GUARDIAN AND/OR ELIGIBLE STUDENT.

In reference to records released directly from a private evaluator:
A fax or photocopy of this Agreement is as binding and effective as the original. This Agreement may be revoked at any time except in the event that the disclosing agency has taken action in reliance on it. Unless previously revoked, this Agreement will terminate sixty (60) days following the parent(s) signature date noted below or the specific date noted here: _____/_____/_____. **IN WITNESS WHEREOF, I/We have carefully read and understood all terms of this Release of Confidential Information and indicate with my/our signature voluntary execution of this Agreement.**

_____

Print Name(s): **Check One: ☐ Parent ☐ School Personnel**

Authorized Signature(s):	Title:	
Address:	City:	Zip:
Phone:	Date:	