GENEVA COMMUNITY UNIT SCHOOL DISTRICT 304
RELEASE OF INFORMATION
FROM THE OFFICE OF STUDENT SERVICES

Name of Child_____ D.O.B._____ Date_____

Address _____

As the parent or legal guardian of the above named child, I hereby grant permission to the **Geneva School District 304** to exchange confidential information, records, and reports concerning my child with:

_____

(name of agency, school district, physician, individual, etc.)

The purpose of this authorization is: assessment, evaluation, and educational planning
Other:

District 304 contact information: Anne Scalia, Director 630-463-3060
Jamie Benavides, Assistant Director 630-463-3066
Other: _____

Check the items listed below that you DO NOT WANT SENT, otherwise, the entire record will be forwarded.

___Social History	___Medical Eval. /Records	___Psychological Evaluations
___Achievement Testing	___OT/PT Therapy Reports	___Social Work/Counselor Reports
___Anecdotal Records	___Disciplinary Information	___Mental Health Records/ Assessments
___Verified Information from Non-Educational Agencies		___Other (specify) _____

I understand that I have the right to inspect, copy, or to challenge the contents of the records prior to the records being forwarded.

I understand that it is my right to revoke this consent at any time in writing.

I understand that my refusal to permit such transmittal may limit the available database for diagnostic evaluation for evaluation and treatment services.

I understand that received information cannot again be given to any other agency or person by the recipient without written consent.

This authorization will automatically expire one year from the date listed below.

_____ _____
Date Signature of Student over age of 12

_____ _____
Date Signature of Parent/Guardian

_____ _____
Address Phone