

**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 Giarrante, 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.

- |                                                                             |                                                   |                                                             |
|-----------------------------------------------------------------------------|---------------------------------------------------|-------------------------------------------------------------|
| <input type="checkbox"/> Social History                                     | <input type="checkbox"/> Medical Eval. /Records   | <input type="checkbox"/> Psychological Evaluations          |
| <input type="checkbox"/> Achievement Testing                                | <input type="checkbox"/> OT/PT Therapy Reports    | <input type="checkbox"/> Social Work/Counselor Reports      |
| <input type="checkbox"/> Anecdotal Records                                  | <input type="checkbox"/> Disciplinary Information | <input type="checkbox"/> Mental Health Records/ Assessments |
| <input type="checkbox"/> Verified Information from Non-Educational Agencies | <input type="checkbox"/> 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 \_\_\_\_\_