Student Support Services

Interagency Release of Information

Between the Alachua County Public Schools and Outside Agencies/Providers

I, _____, hereby authorize
Full Name

_____
Name of Agency and/or Provider

_____ _____
Address City State Zip Telephone

To share/release the information marked below:

About _____ _____/_____/_____
Student's Full Name Date of Birth

To and From: _____

_____ _____
Address City State Zip Telephone

Please share/release the following records:

- ☐ Psychological Evaluation
- ☐ Grades/Educational Tests
- ☐ Medical Evaluation/health Records
- ☐ Medications
- ☐ Educational Evaluation
- ☐ Current Withdrawal Grades
- ☐ Other: _____
- ☐ Treatment Issues

These records are being shared for the purpose of:

☐ To assist in the treatment/education program of the student
☐ Other

This information is for professional use only and will be handled in a manner to respect and protect confidentiality.

I further understand that I have the privilege of revoking this at any time, providing I submit written notice. However, this will not effect information released prior to revocation.

Your signature on this form authorizes release of the above records. This form shall be valid for ☐ one calendar year from the signature date below or ☐ a single disclosure.

_____ _____
Students' Legal Name Parent or Guardian (Signature)

_____ _____
Date of Birth Date