**AUTHORIZATION TO EXCHANGE / DISCLOSE COMMUNICATIONS AND RECORDS**

TO: _____ RE: _____
Name

_____ _____
Date of Birth

_____ _____

_____

_____
Address

The affixed signature (s) gives permission to _____
_____ and to the agency or person to whom this form is addressed, to exchange restricted / confidential communications and records as listed regarding the above named individual.

These communications and records are intended for use in making decisions regarding educational /treatment/ _____ planning as mandated by State and/or Federal law and are accessible to parents upon request.

The person (s) authorizing the exchange/disclosure of communications and records has the right to revoke this consent by written statement at any time and to inspect and copy the records. (Information released prior to revocation is not affected.)

This "Authorization to Exchange/Disclose Communication and Records" is valid for one year (until_____) or through _____.

Failure to sign this form will prevent the exchange/disclosure of communications and records and may result in inappropriate educational /treatment _____/ planning.

Communications and records being exchanged/disclosed: (If mental health records are being sent, please identify them according to agency, type of information and date of reports.)

_____

_____

_____

| | |
|---|---|
| _____ | _____ |
| Date | Parent or legal Guardian |
| _____ | _____ |
| Date | *Individual (if 18 or older, or 12 through 17 if mental health records are being sent). |
| _____ | _____ |
| Date | Witness |

*Note: If the individual, who is 12 through 17 years of age, refuses to authorize the release of mental health records, the student's refusal can be overruled by certified school/mental health personnel upon a showing to _____
School Admin. /Mental Health Therapist that the release is believed to be in the best interest of the individual.

PAEC/408 (02/04)