



*Education that inspires...Opportunities for all*

# GURNEE SCHOOL DISTRICT 56

3706 Florida Avenue • Gurnee, IL 60031 • 847-336-0800 • www.d56.org

## STUDENT RECORDS AUTHORIZATION TO REQUEST/RELEASE COMMUNICATIONS AND RECORDS

Name of Student: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**I AUTHORIZE:**

Gurnee School District 56  
3760 Florida Avenue  
Gurnee Il 60031

Attention:

**TO EXCHANGE INFO WITH:**

Name: \_\_\_\_\_

Street: \_\_\_\_\_

City/Zip: \_\_\_\_\_

The affixed signature(s) gives permission to Gurnee School District 56 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 and therapeutic evaluations and planning as mandated by the State and/or Federal law and are accessible to parents upon request.

This release will be copied and sent with the information requested. This authorization grants permission to Gurnee School District 56 to establish phone contact if necessary for the purpose of requesting records and information for the student's educational and therapy program.

**Description of Record Requested:**

- |   |   |
|---|---|
| <input type="checkbox"/> Student Temporary Records            | <input type="checkbox"/> Student Permanent Records                      |
| <input type="checkbox"/> Medical/Physical Exam/Health Records | <input type="checkbox"/> Ophthalmological/Ocular                        |
| <input type="checkbox"/> Educational Assessment               | <input type="checkbox"/> Dental   |
| <input type="checkbox"/> Psychological Evaluation             | <input type="checkbox"/> Hearing and Vision Screening                   |
| <input type="checkbox"/> Psychiatric Evaluation/Reports       | <input type="checkbox"/> Speech and Language Evals/Report               |
| <input type="checkbox"/> Education Progress Reports           | <input type="checkbox"/> OT and PT Reports                              |
| <input type="checkbox"/> Audiological Reports                 | <input type="checkbox"/> Treatment and Progress Notes (hospitalization) |
| <input type="checkbox"/> Child Review/IEP                     | <input type="checkbox"/> Other _____                                    |

The information provided to District 56 will become part of the student's records and will be shared with the appropriate personnel responsible for the implementation of the student's program in accordance with the federal and state law.

**ILLINOIS MENTAL HEALTH AND DEVELOPMENT DISABILITIES CONFIDENTIAL ACT.**

The authorization will be good for one year from the date of this signing, \_\_\_\_\_, and limited to only that information I have requested above to be sent to the facility named herein and that it not be further disclosed or used for any purpose other than as stated in the authorization. It is further understood that I have been advised by the facility that I have the right to revoke the consent at any time during it's validity.

I understand that my refusal to consent to the release of the information specified above will prevent disclosure of such information to the facility named herein.

\_\_\_\_\_  
(Parent/Guardian) \_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Student Signature 12-17 yrs. required, if mental health records are being released.) \_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Witness, if mental health records are being request/released.) \_\_\_\_\_  
(Date)

\* Mental Health Records (only): Adult 18 or over; Parent/Guardian and child, if 12 thru 17, Parent/Guardian, if child under 12 or patient adjudicated incompetent.