Authorization to Release or Receive Student Information

Student Name _____ Date of Birth _____

School Name _____ Grade _____ School Year _____

Information may be shared between the following institutions:

(School)	**(School, Agency or Individual)**
Kearney Public Schools	
KPS School _____	_____
Address _____	_____
City, ST, Zip _____	_____
Phone _____ Fax _____	Phone _____ Fax _____

Records to be requested an/or released are:

☐ Please release all records pertaining to this student: cumulative school records, including, but not limited to: directory information, attendance records, transcripts, health records, standardized test results and activities participation; subsidiary school records such as those listed below.

Subsidiary school records, specifically:

- ☐ Student Assistance Team Report (Prereferral Information)
- ☐ Multi Disciplinary Team Report (Including:)
  - ☐ Psychological Testing Results
  - ☐ Speech/Language/Hearing Results
  - ☐ Physical Therapy Results
  - ☐ Outside Agency Reports (specify) _____
- ☐ Individualized Education Plan (IEP)
- ☐ Section 504 Records & Plans
- ☐ Disciplinary Records
- ☐ High Ability Records (Gifted)
- ☐ Occupational Therapy Results
- ☐ Teacher/Couselor Observations
- ☐ ELL (English Language Learner)
- ☐ Other (specify) _____

Medical Information, specifically:

- ☐ Physical assessments/screening
- ☐ Immunization
- ☐ Care Plans/Individual Health Plans
- ☐ Health History
- ☐ Medications (current and history)
- ☐ Other specific information to be disclosed: _____

Purpose of Medical Information: _____

This authorization is valid for one year. I understand that I may revoke this authorization at any time by submitting written notice. I recognize that these records may not be protected by HIPPA Privacy Rule, but will become education records protected by FERPA. Verbal or written information will only be shared with appropriate staff for legitimate education purpose.

Parent/Guardian Signature _____ Date _____

Submit by Email | Print Form