English

Authorization to Request and Release Information

Santiam Canyon School District 129J
Authorization to Request and Release Information

Date:_____
(mm/dd/yyyy)

Name of Student: _____

Parent or Guardian: _____

This letter is an official document that gives the school district permission to ask for certain information and give out information about you and your student. This information is needed so that the school district can help get services for you, your student, or both. We will keep personal information confidential and only use this information when needed. If you need assistance understanding this letter, please contact:

Name:_____ Title: _____

Email:_____ Phone: _____

Do you need an interpreter? Please tell us and we will make sure one is available.

I authorize employees of _____ to request and release any records, reports (including academic and behavioral reports), evaluations, documents, and any other information in our possession regarding me, my family, or both to other organizations, agencies, or businesses for the purpose of obtaining resources on my or my family's behalf. I have been fully informed that this information may include the following:

- Eligibility for certain programs
- Academic Progress, including academic reports and tests
- Service Plans
- Social History
- Financial and other benefits
- Information related to health, including mental health and drug, or alcohol use, or both; and
- Behavioral reports

I understand that all staff members of _____ have an obligation under law to keep all information confidential concerning my child and my family.

I also understand that the following agencies and organizations may be included in my authorization to release and request information. (please initial all that apply.)

❑ I authorize <u>all the agencies marked below to release and request information</u> regarding myself and my children.

____
____Colleges or Universities
____Local Housing Authority
____Faith Based Agencies
_____Other _____

___ Temporary Shelters
___ TANF (Temporary Assistance for Needy Families)
___ Local Public Assistance
___ Hospitals, Clinics and Other Medical Treatment Centers

This authorization to request and release information will not last for more than one year and will expire on the following date _____ *(mm/dd/yyyy)*.

The information in this form has been explained to me. I understand the information that may be released and the information that may be requested. I also understand that there are laws protecting the confidentiality of authorized information. I understand that this authorization is voluntary and is valid until the request is fulfilled. I further understand that I may cancel this authorization in writing at any time. Canceling this authorization does not apply to any action based on this authorization that has already been taken.

Parent or Guardian Signature: _____ Date:_____
(mm/dd/yyyy)

Staff Signature: _____ Date:_____
(mm/dd/yyyy)