



Kansas Instructional Support Network
Kansas State Department of Education – Special Education Services

CONSENT FOR RELEASE AND/OR EXCHANGE OF INFORMATION

Student Name: _____ Date of Birth: _____

School Name/USD#: _____

Parent Name: _____ Phone: _____

Address: _____

Parent E-Mail Address: _____

(Please print clearly)

I HEREBY CONSENT TO THE RELEASE AND/OR EXCHANGE OF:

- | | |
|---|---|
| <input type="checkbox"/> Speech & Language Information | <input type="checkbox"/> Social/Psychological Evaluation |
| <input type="checkbox"/> Audiological Assessment | <input type="checkbox"/> Individual Education Program - IEP |
| <input type="checkbox"/> Medical Information | <input type="checkbox"/> Screening Results |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Neuropsychological Evaluation |
| <input type="checkbox"/> Intake/Admission Report | <input type="checkbox"/> Direct Observation |
| <input type="checkbox"/> Exchange of Information Over Telephone | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Family Assessment | _____ |
| <input type="checkbox"/> School Records/Reports | _____ |

Parents should verify the agencies/programs named by initialing each agency listed.

(Name/Agency) (Address & Phone #) (Parent/Guardian Initials)

School: _____

Medical: _____

Other: _____

The purpose of this request is to: _____

I understand the information obtained will not be transmitted to another party without my specific written consent or as otherwise permitted by federal regulations. (Title 45, Part 99.30 - 99.37)

(Parent/Legal Guardian Signature)

(Relationship to Student)

(Date)

This consent will expire one year from the date of signature, unless revoked in writing prior to that date.