ANCHORAGE SCHOOL DISTRICT
CONSENT FOR RELEASE OF EDUCATION RECORDS
AUTHORIZATION FOR USE AND/OR DISCLOSURE OF EDUCATION RECORDS

The Family Educational Rights and Privacy Act (FERPA) is a federal law that protects the privacy of student education records created or maintained by a school that receives federal funds. Completion of this document authorizes the disclosure and use of education records as described below. Completion also authorizes you to discuss this information with representatives of the organization named below entitled to receive said information.

STUDENT INFORMATION:

Student Name: _____ Date of Birth: _____

Social Security Number: [redacted] Grade: _____

School: Early Intervention Services Center

Parent/Legal Guardian Name: _____

Relationship to Student: _____

USE AND DISCLOSURE INFORMATION:

I, the undersigned, do hereby authorize FOCUS Infant Learning

(*name of agency or educational institution maintaining records*)

to disclose and deliver the complete education records maintained under the above student's name including but not limited to the following:

* Grades and transcripts
* Psychological & Educational testing
* Verbal Information
* School health records
* Special education records
* Discipline

***Please list any records you do not wish to be disclosed*: _____

The education records described above shall be delivered to:

Name: Early Intervention Services Organization: Anchorage School District

Address: 5530 E Northern Lights Blvd

City/State/Zip Code: Anchorage, AK 99504 Telephone Number: 907-742-2657

PURPOSE:

This information is to be disclosed and used for the purpose of:

☑ Special Education Evaluation & Planning
☑ Provision of Special Education Services
☐ Other _____ (*please provide explanation*).

☐ § 504 Evaluation & Planning
☐ Information for School Nursing

AUTHORIZATION FOR REDISCLOSURE:

Under federal law, the requestor (School District) may not redisclose the information identified above to any other party without your prior consent. If you wish to authorize the School District to redisclose the information identified above please mark the box below:

☐ I authorize the School District to redisclose the education information described above and I understand that if the information is redisclosed it may not be protected by federal privileges, privacy laws or regulations.

APPROVAL:

My authorization for the use, disclosure and/or redisclosure of the information identified above is voluntary. I understand that the information to be disclosed or redisclosed may include individually identifiable health information. I understand that, upon my request, I am entitled to a signed copy of this authorization form and the records to be disclosed. Unless sooner terminated in writing, this release shall remain effective for **1 year** from the date signed below. A copy of this release shall be as sufficient to authorize release of information identified above as the original signed by me.

_____ Date: _____

Signature of Student's Parent or
Student's Legal Guardian

Relationship: _____