

PARENT/GUARDIAN/STUDENT CONSENT FOR RECORDS RELEASE

TO: _____ RE: _____
(Student Name)

(Street Address) AGE: _____ BIRTHDATE: _____

(City, State, Zip Code)

FROM:

Psychological Services
Mad River Local School District
801 Old Harshman Road
Dayton, Ohio 45431

We are requesting the following information/records for the above-named student:

- ☐ All personally identifiable data on file.
☐ The following records only: (please specify)

Reason for request: (please check)

- ☐ To aid in making present and future educational decisions.
☐ Other: (please specify)

With the understanding that the district cannot assume responsibility for the confidentiality of educational information disclosed, I authorize you to release educational information regarding the above-named student in the manner indicated.

(Date)

(Signature of parent/guardian or student, if 18 or older)

(Address)

(City, State, Zip Code)

FOR OFFICE USE ONLY

Date Data Released _____ by _____
(Name/Position)
Date Copies Mailed _____ by _____
(Name/Position)