BHASED
Black Hawk Area Special Education District

4670 11th Street
East Moline, IL 61244
309-796-2500
309-796-2911 Fax

Christan Schrader
Director

AUTHORIZATION FOR EXCHANGE OF CONFIDENTIAL INFORMATION

I, _____, ☐ parent ☐ legal guardian ☐ surrogate parent ☐ student (over 18),

authorize **Black Hawk Area Special Education District** to exchange records checked below, regarding,

_____, _____/_____/_____, with _____
STUDENT BIRTHDATE

_____, _____,
NAME & TITLE PHONE

_____
AGENCY, STREET ADDRESS, CITY, STATE, ZIP CODE

for the purpose of _____,

NOTE: Non-public school agencies, private providers and such that do not accept this form, must provide their own.

RECORDS TO BE EXCHANGED

☐ I authorize the exchange of all school student records.

I authorize the release of the following student records, as designated below:

☐ Academic Transcript ☐ Psychiatric ☐ Social/Behavioral Records

☐ Attendance Records ☐ Psychological ☐ Special Education Records/IEP

☐ Audiology, Speech, Physical or Occupational Therapy Evaluations/Reports

☐ Disciplinary Information

☐ Educational Evaluation & Reports

☐ Medical/Health Records

☐ Other:_____

This consent is valid until _____/_____/_____.

I understand that I have the right to inspect, copy, and challenge the content of the school student records for which I am authorizing exchange. I also have the right to designate the school student records to be exchanged or to identify specific portions of a school record to be exchanged by this consent. Any such limitations have been noted above. I understand that, by written request, I may revoke this consent at any time except to the extent to which action has already been taken on this authorization.

_____ _____
PARENT SIGNATURE DATE

_____ _____
STUDENT SIGNAURE (if age 12 or older) DATE