



**WILL COUNTY SCHOOL DISTRICT 92  
AUTHORIZATION FOR RELEASE OF RECORDS\***

**\*Please complete BOTH sides of the HIPAA form and  
attach it to this Release of Records form.**

**Student for whom records are being requested:**

Last Date of Attendance \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

School Last Attended \_\_\_\_\_ Current Grade \_\_\_\_\_

Parent/Guardian Name(s) \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

**Transfer School:**

Person/Agency \_\_\_\_\_ Attention \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

**Information to be disclosed from District (start date through transfer out date)** \_\_\_\_\_

**Information to be disclosed, including all school student records:**

- attendance/scheduling/transportation
- special education records
- school health records
- discipline records
- mental health records
- diagnostic test reports
- report cards
- transcripts
- developmental disabilities records
- recommendations/suggestions
- substance use/abuse information
- behavior plans
- social history
- consultation reports
- psychiatric records
- other (describe):

**Expiration of Authorization:** This authorization is valid until: (Month/Day/Year) \_\_\_\_\_

Unless an earlier expiration is specified, the authorization will expire 12 months from the date of the signature, below.

**I understand that:**

1. I am authorizing the disclosure of the above-referenced records.
2. I have the right to copy and inspect the information being disclosed.
3. I have the right to revoke this authorization, in writing, at any time by sending such written notification to my provider's office. However, my revocation will not be effective to the extent that my provider has taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
4. The statutes that govern this authorization include but are not limited to: 20 U.S.C. 1232g, 105 ILCS 10/1 *et seq.*, 740 ILCS 110, 735 ILCS 5/8-2001, any other relevant confidentiality code of Illinois, and, if applicable, 820 ILCS 40/0.01.
5. If I refuse to consent to the release of information specified above, the following are the consequences:

**Signature:**

Signature of Student (over the age of 12) \_\_\_\_\_ Date \_\_\_\_\_

(For purposes of release of mental health or developmental disabilities information)

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

(Or signature of a student who is emancipated or over the age of 18)

Signature of Witness \_\_\_\_\_ Date \_\_\_\_\_

(For purposes of release of mental health or developmental disabilities information)