AUTHORIZATION FOR EXCHANGE OF CONFIDENTIAL INFORMATION

Eastern Illinois Area of Special Education

5837 Park Drive
Charleston, IL 61920
Phone: 217-348-7700 Fax: 217-348-7704

Name of Child	Birthdate
Address	

As the parent or legal guardian of the above named child, I hereby grant my permission to the_____

_____ to exchange confidential information concerning my child with:

_____

Name of Agency, School District, Individual, etc.

The purpose of this authorization is: _____

_____

I understand that my permission covers the release of permanent and temporary records, as well as the release of confidential records and reports. I also understand that I have the right to inspect and copy school records, to challenge the contents of these records and/or limit this consent to specific records which I have designated below:

_____

_____

_____

_____

_____

_____

_____

This authorization terminates one calendar year from the date of permission.

_____ _____

Date Signature of Parent/Guardian or Adult Student Over Age 18

_____ _____

Address Phone

Article 3.04(3)
(Based on the Illinois School Student Record Act of 1975)
Article 50, The School Code of Illinois

Original: Student's Temporary Record
(EIASE or Local District)
Rules and Regulations to Govern
School Student Records