



CAESAR RODNEY SCHOOL DISTRICT
 7 FRONT STREET
 P.O. BOX 188
 WYOMING, DE 19934

AUTHORIZATION FOR RELEASE OF INFORMATION

Student Name:		Birth date:	
Address:			
Home Phone :		Other:	
Parent/Guardian:			
Relationship to Student:			
Address:			
Home Phone :		Other:	

I hereby authorize _____
 To disclose the information described below concerning the above named student to be released to the Caesar Rodney School District for the purpose educational programming/ planning of the above named student.

The following information may be disclosed/released

Any and all records on student	Psychological Test Results
Medical records	Psychological Evaluations
Educational Records	Psychiatric Evaluations
Discipline Records	Speech Therapy Information
Evaluation Reports	Occupational Therapy Information
Educational Plans	Physical Therapy Information
Other:	Other:

I understand that I have the right to revoke this authorization at any time but not retroactive to the release of the information made in good faith. Except to the extent that the Caesar Rodney School District has taken action in reliance on this Authorization, I have the right to revoke this Authorization by giving written notice addressed to Director of Student Services, Caesar Rodney District Office, P.O. Box 188, Wyoming, DE 19934. I understand the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA privacy rule.

Witnessed by:

 Name:

 Parent/Legal Representative*

 Date

**This authorization is valid from the date signed for the duration of the _____ academic school year unless revoked in writing before that date.*