Transition Plus
9400 Cedar Lake Road
St. Louis Park, MN 55426

Consent To Release Private Data

Student Name: Date Sent:
Student ID: School: Transition Plus
Birthdate: Grade:

Parent/Guardian Name: _____
Address: _____
Phone Number: _____

I authorize: Transition Plus staff and/or Britta Nelson, School Nurse

To have records: **released to** / **obtained from** / **released to and obtained from** (circle one):

Name: _____
Organization: _____
Address: _____
_____

Student records may be examined by the parent/guardian, or student if age 18 or older.

The information to be released includes:

- ☐ Health Records
- ☐ Psychological Records
- ☐ Special Education Results
- ☐ Teacher, Counselor, Staff Observations
- ☐ Medical Reports, immunizations, audiological, vision, physical exam, allergies, etc.
- ☐ Chemical Dependency/Abuse Reports
- ☐ Social Work Records
- ☐ Psychiatric Reports
- ☐ Other: Current IEP and most recent evaluation
- ☐ Official School Records (name, address, birthdate, sex, attendance record, grade, grades, class rank, standardized group test results)

The purpose of this request is:

_____

_____

I understand that this authorization takes effect the day I sign it. This permission is valid for no more than one year from the date of my signature.

I also understand that I may change this authorization at any time.

_____ _____
Parent/Guardian Signature or Student if 18 or older **Date**

Date received by District	Expiration Date

Copies: Parent/Guardian
Building Due Process File