

|                                |              |                                   |               |
|--------------------------------|--------------|-----------------------------------|---------------|
| _____<br>Legal Name of Student | _____<br>DOB | _____<br>State Student ID (SASID) | _____<br>Date |
|--------------------------------|--------------|-----------------------------------|---------------|

**REQUEST TO RELEASE OR SECURE CONFIDENTIAL INFORMATION**  
(Not required for release to another Administrative Unit)

This permission shall be valid for the following duration. Beginning \_\_\_\_\_ and shall terminate \_\_\_\_\_

| Indicate Consent   | Records/information to be released or secured: | Indicate Consent   | Records/information to be released or secured: |
|--|--|--|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Audiometric           | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Psychological         |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Educational           | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Physical Therapy      |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> IEP                   | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Social Work           |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Medical               | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Speech/Language       |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Occupational Therapy  | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Other: _____          |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Psychiatric           | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Other: _____          |

|                  |       |       |
|------------------|-------|-------|
|                  | From  | To    |
| Agency           | _____ | _____ |
| Address          | _____ | _____ |
| City, State, Zip | _____ | _____ |

All information released or secured will be in compliance with the Family Education Rights and Privacy Act and the Colorado Open Records Law. No additional information will be released or secured without prior approval from the parent, except as provided by law.

**PARENTAL CONSENT**

I understand that consent is voluntary and may be revoked at any time in writing. I hereby authorize the transfer of information as indicated above.

\_\_\_\_\_  
Signature (Parent/Guardian/ESP)

\_\_\_\_\_  
Date

Date consent received by District/Administrative Unit: \_\_\_\_\_