Warwick Public Schools

69 Draper Avenue Warwick, RI 02889

Phone: (401)734-3000~ For Records: (401)734-3057~Fax: (401)734-3060

Release of Records Information

STUDENT:________________________ D.O.B. ___/___/___ SCHOOL:____________________ GRADE:___

TEACHER/COUNSELOR:____________________ PARENT/GUARDIAN:____________________

ADDRESS:______________________________ Email:____________________

TELEPHONE:(c)____________________ (h)____________________ (w)____________________

Authorization for the person(s)/agencies named below to:

_____ Release to: _____ Obtain from: _____ Exchange with: _____Verbal exchange only,
confidential information including protected healthcare information, regarding the above named student;

PERSON/AGENCY:________________________ Phone: ________________________

ADDRESS: ____

Fax Number: ____________________ Email Address:____________________

Records to be released/disclosed*

____ Psychological ____ Psychiatric/Clinical Psychological ____ Educational

____ Social History ____ Speech/Language ____ Medical

____ IEP ____ Health Records ____ Other

The purpose of release/disclosure is:

_____ to assist in educational planning _____ to assist in transfer to a new school district*

_____ to share evaluation/re-evaluation results _____ to plan for transition

_____ at the request of the parent _____ other: ____________________

Please check appropriate box below:

_____ I have been fully informed and understand the school's request for my consent, as described above. This information will be released/disclosed upon receipt of my written consent.

_____ I understand that my consent is voluntary and may be revoked in writing at any time. However, I understand that revocation is not retroactive (i.e. it does not negate an action that occurred after the consent was given and before the consent was revoked).

_____I understand that the above-named student's education will not be conditioned on whether I sign this authorization.

_____ I give my permission for the identified records to be released/disclosed to the above named person/ agency.

SIGNATURE OF PARENT/GUARDIAN________________________________ DATE____________________

SIGNATURE OF STUDENT (18 YEARS OR OLDER) ________________________________ DATE____________________

*Parent authorization is not required to transfer educational records to another school district.
This consent expires one year after the above date and may be withdrawn at any time.