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| <b>Minnesota State Academy for the Deaf</b><br><b>615 Olof Hansen Drive</b><br><b>Faribault, MN 55021</b> | <b>Consent to<br/>Release Private Data</b> |
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Parent, this form allows information about your child to be exchanged. Please sign and return it to the school (address below).

Month/ Day / Year: \_\_\_\_\_  
Learner's Full Name: \_\_\_\_\_  
ID Number: \_\_\_\_\_  
School: \_\_\_\_\_ Grade: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_

I authorize (school) \_\_\_\_\_ District # \_\_\_\_\_  
(Name, Title) \_\_\_\_\_ (phone) \_\_\_\_\_  
(Address) \_\_\_\_\_  
(City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip) \_\_\_\_\_

to release information to:  to obtain information from (Check either or both boxes, as needed)

(Name, Title) \_\_\_\_\_ (phone) \_\_\_\_\_  
(Organization) \_\_\_\_\_  
(Address) \_\_\_\_\_  
(City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip) \_\_\_\_\_

School records may be examined by parent, or learner if of legal age.

The information to be released:

- Official School Records (name, address, birth date, sex, attendance record, grade level, grades, class rank, standardized group test results)
- Health Record
- Psychological reports
- Special Education Records (including related services)
- Teacher, Counselor, Staff Observations
- Others (specify) \_\_\_\_\_
- Others (specify) \_\_\_\_\_
- Chemical Abuse / Dependency Report
- Medical Report (including related services)
- Psychiatric Report
- Social Work Report

The purpose for the request:

I understand that this authorization takes effect the day that I sign it. It expires on \_\_\_\_\_ (Month, Day, Year) or no more than one year from the date of my signature.

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

\_\_\_\_\_  
Parent Signature (or learner, if of legal age)

\_\_\_\_\_  
Month/Day/Year

Copies: Learner File  
\_\_\_\_\_  
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