	Minnesota State Academy for the Deaf **615 Olof Hansen Drive** **Faribault, MN 55021**	**Consent to** **Release Private Data**

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
☐ Chemical Abuse / Dependency Report
☐ Medical Report *(including related services)*
☐ Psychiatric Report
☐ Social Work Report
☐ Others *(specify)* _____
☐ Others *(specify)* _____

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
_____
_____

Submit Form Print Form