CONSENT FOR RELEASE OF INFORMATION
BLUE SPRINGS R-IV SCHOOL DISTRICT

1801 NW Vesper, Blue Springs, MO 64015

I authorize Blue Springs R-IV School District to **receive/disclose information from the records of:**

School or Agency _____

Name/Title of Person _____

Address _____

City, State, Zip _____

Telephone #. _____ FAX # _____

the following information from the school records of:

_____ _____
Name at time of Graduation Maiden Name (if applicable)

_____ _____ _____
Date of Birth High School Attended Year of Graduation or Year would have graduated

I hereby authorize disclosure of the records listed below (check).

___ Cumulative Permanent School Records
___ Health Records/Immunizations
____ Special Education Record
____ Psychological Reports & Evaluation Psychological Tests
____ All of the above, if applicable
____ Other: _____

The purpose of this disclosure is for the following reason (s): _____

_____

This authorization for release of information shall expire on _____ or one year after the date signed, if an expiration date has not been provided.

The consent to disclose may be revoked at any time except to the extent of action that has been taken.

I understand that a copy of this information is available to me upon written request.

_____
Parent/Legal Guardian or Student if over 18 years of age (Printed Name)

_____ _____
Signature of Parent/Legal Guardian or Above Student *Date*

***Information requested in accordance with HIPAA and FERPA (08/04/03)*

Revised 4/7/08