AUTHORIZATION FOR THE RELEASE OF EDUCATIONAL, MEDICAL, PSYCHOLOGICAL OR OTHER TREATMENT RECORDS AND INFORMATION

(MUST BE WITNESSED BY A SCHOOL BOARD EMPLOYEE OR NOTARIZED)

I, _____, the parent/guardian of _____, whose student ID number is _____ or social security number is (last 4 digits only) XXX-XX-__ __ __ __ and whose date of birth is _____, HEREBY AUTHORIZE the custodians of the Child's records, to furnish and release all student or patient records pertaining to the Child, maintained in their custody and control, including, but not limited to all student records, medical evaluations, psychological evaluations, and any other pertinent records that may be deemed necessary by the receiving party for the purpose of:

☐ Review ☐ Evaluation ☐ Diagnosis ☐ Development of Education Plan ☐ Other

Such authorization shall also provide for the oral exchange of information between the designated parties regarding the child.

☐ **Hernando County Public Schools, Florida (HCSB) is authorized to release:**

TO: _____
(Name of recipient)

_____
(Address)

_____

_____

********** OR **********

☐ _____ is authorized to release:

TO: **Hernando County Public Schools**

_____
(Name of School)

_____
(School Contact)

_____
(School Address)

_____

The foregoing authorization shall expire after 2 years from the date of this authorization or until revoked by me in writing to the custodian of such records. **The records may be released upon receipt of a copy or fax of this authorization.**

DATED this_____ day of _____, 20 ___.

WITNESS (must be an HCSB employee)

_____
(Signature)

_____
(Printed)

_____
(School/Department/Title)

Identification Verified (Include Number):

_____
(State issued Driver's License, State issued photo ID or passport)

PARENT or GUARDIAN

_____
(Signature)

_____
(Printed)

_____
NOTARY PUBLIC
STATE OF _____AT LARGE
COMMISSION EXPIRES: _____

SO-SS-008
Revised 06-07-2010
Online Only

PHOTOCOPIES NOT ACCEPTED