CONSENT FOR RELEASE OF STUDENT DATA/RECORDS

Student Name: ________________________________ Date of Birth __________________________

Name of School_______________________________ School ID # ___________________________

Student Address ____

Home Telephone #: ______________________

Parent/Legal Guardian (1) Mobile Telephone # ___________________________

Parent/Legal Guardian (2) Mobile Telephone # ___________________________

I authorize the Gloucester County Public Schools Division to release to the individual or Agency identified below identifying educational/medical data and records (the "Records") of the student listed above. I understand that in addition to educational records and data, such Records may also contain health information pertaining to diagnosis and treatments, immunization records, suspensions/office referral data, attendance data, referrals to student service teams, as well as written communications with school staff related to mental health interventions.

Time Period During Which Release of Student/Data is Authorized:

From: Date that form is signed below.

Until:

____

Name of Authorized Individual or Agency

Name and Title____

Agency Name (if applicable) ____

Address (1) ____

Address (2) ____

Email Address ____

Phone Number____

Fax Number____

Signature of Parent/Guardian ______________________________________

Name of Parent/Guardian ______________________________________

Relationship to Student ______________________________________

Date ______________________________________

Witness ______________________________________

ADOPTED: November 12, 2013

CROSS REFERENCE: JOD Release of Student Data/Records