# School-Seal-new-color

**LOWELL PUBLIC SCHOOLS**

## Henry J. Mroz Administration Office

155 Merrimack Street

Lowell, Massachusetts 01852

**AUTHORIZATION FOR INFORMATION AND RECORDS**

**STUDENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_D.O.B:\_\_\_\_\_\_\_\_\_ SCHOOL:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, (student or parent/legal guardian is student is a minor) understand that in order for Lowell Public Schools to provide the most appropriate educational program and related services for my child, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, there must be an exchange of information between the persons and/or agency listed below, who have or had knowledge of my child and/or who may be significant providers of service to my child and/or my family, and the staff of the Lowell Public Schools.

I understand that Lowell Public Schools is requesting this information for the purpose of evaluating/assessing/monitoring my child’s strengths and needs, in an effort to provide an appropriate educational program.

I **authorize the Lowell Public Schools** to **\_\_\_\_Obtain \_\_\_\_Release** **t**he following information (verbal/written) by circling the choices below or by checking “All Records Listed”.  **This RELEASE will be valid for ONE YEAR from the date of signature**, unless you specify a different time period (insert alternative time period here) to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_from:\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

|  |  |  |
| --- | --- | --- |
| **General Education**All Records Y N Educational Records Y N(Photo\_\_Video\_\_ ) Attendance Y NDiscipline Records Y NSchool Health Records Y NCurrent 504 Y NTwo way Communication Y NAlternative Placement Y N | **Special Education**All Records Y NSPED Records Y NCurrent IEP Y NIndependent Evaluation Y NPhysical Therapy/Eval Y NOccupational Therapy/Eval Y NPsychological Eval Y NSpeech & Language Therapy/Eval Y NSocial History Report Y N | **Other**All Records Y NPsychiatric Summary Y NDischarge Summary Y NDetailed Medication History Y NHospital/MedicalRecords Y NMedical Summaries Y NProtected Info Y N(Protected Info Release is required)Current Treatment Plans Y N(Behavior, Safety, Other)Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Y N |

I understand that this authorization is subject to revocation at any time, with written notice by the Parent/Student or other responsible party, except to the extent that action has been taken in reliance thereon. I also understand that these records are protected under Federal and State regulations governing the confidentiality of student records.

 TO/FROM: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Name of Individual/School/Institution/Agency/Physician

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Complete Mailing Address

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 City/Town State Zip

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent/Legal Guardian/Student Telephone Number Date

*www.lowell.k12.ma.us*