



**LOWELL PUBLIC SCHOOLS**  
 Henry J. Mroz Administration Office  
 155 Merrimack Street  
 Lowell, Massachusetts 01852  
 www.lowell.k12.ma.us

**AUTHORIZATION FOR INFORMATION AND RECORDS**

**STUDENT INFORMATION:**

**LAST:** \_\_\_\_\_ **FIRST:** \_\_\_\_\_ **MIDDLE:** \_\_\_\_\_ **D.O.B:** \_\_\_\_\_

**GRADE:** \_\_\_\_ **GENDER:** \_\_\_\_ **LASID#:** \_\_\_\_\_ **PARENT/GUARDIAN:** \_\_\_\_\_

**SCHOOL:** \_\_\_\_\_ **ADDRESS:** \_\_\_\_\_

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 the 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: \_\_\_\_\_.

<b>General Education</b>		<b>Special Education</b>		<b>Other</b>	
All Records	Y N	All Records	Y N	All Records	Y N
Educational Records (Photo_Video_)	Y N	SPED Records	Y N	Psychiatric Summary	Y N
Attendance	Y N	Current IEP	Y N	Discharge Summary	Y N
Discipline Records	Y N	Independent Evaluation	Y N	Detailed Medication History	Y N
School Health Records	Y N	Physical Therapy/Eval	Y N	Hospital/Medical Records	Y N
Current 504	Y N	Occupational Therapy/Eval	Y N	Medical Summaries	Y N
Two way Communication	Y N	Psychological Eval	Y N	Protected Info	Y N
Alternative Placement	Y N	Speech & Language Therapy/Eval	Y N	(Protected Info Release is required)	
		Social History Report	Y N	Current Treatment Plans (Behavior, Safety, Other)	Y N
				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