Wabash-Miami Area Program for Exceptional Children
246N 300W
Wabash, IN 46992
Telephone: (260) 563-8871~ FAX (260) 563-2749

AUTHORIZATION FOR RELEASE OF INFORMATION

Student: _____ Date of Birth: _____ Age _____

Sex: M _____ F _____ Grade: _____

Parent/Guardian: _____ Telephone: _____

Address: _____ Other Telephone: _____

City: _____ State: _____ ZIP: _____ School: _____

I authorize: Director of Special Education
Wabash-Miami Area Program
246N 300W
Wabash, IN 46992
Attention:

_____ To release information to
_____ To obtain information from

_____
Agency/School

School records may be examined by parent(s) or learner if of legal age.

_____
Address

_____
City State Zip

_____
Telephone

The information to be released:

___ Official School Records (name, address, birth date, sex, attendance record, grade level, grades, class rank, standardized group test results)
___ Health Record
___ Psychological Reports
___ Special Education Records (*including related services*)
___ Teacher, Counselor, Staff Observations
___ Others (*specify*)
___ Others (*specify*)

___ Chemical Abuse/Dependency Report
___ Medical Report (*include related services*)
___ Psychiatric Report
___ Social Work Report

The purpose for the request: _____

Name and address of person initiating this request: _____
_____

I have been informed that I have access to and may review any or all of my child's records and if so desired to challenge the content of the records provided by the Family Educational Rights and Privacy Act (FERPA) of 1974.

I understand that this authorization takes effect the day that I sign it. It *expires* on _____ (Month/Day/Year)
or nor more than one year from the date of my signature.

I also understand that I may change this authorization at any time.

** Signed _____ Date_____