AUTHORIZATION TO DISCLOSE INFORMATION

JAMESTOWN SPECIAL EDUCATION UNIT (JRSEU)
PO BOX 1896
JAMESTOWN, ND 58402-1896
701.252.3376

Name of Student: (Last, First, Middle Initial)			Date of Birth:
Street Address:	City:	State:	Zip Code:

PARENT RELEASE AND SIGNATURE

1. I Hereby Authorize

Name of Person/Agency: **JAMESTOWN SPECIAL EDUCATION UNIT (JRSEU) EDUCATIONAL TEAM MEMBERS**			
Street Address: PO BOX 1896	City: JAMESTOWN	State: ND	Zip Code: 58402

2. To Exchange Information With

Name of Person/Agency to Receive Information:			
Street Address:	City:	State:	Zip Code:

3. The Following Information is Requested: (Be specific)

4. The Information Identified Above Will Be Used For: (List Each Purpose)

5. This Authorization to Disclose Information Remains in Effect Until: (Date)
THREE YEARS FROM THE SIGNATURE DATE BELOW

OR: (Specific Event Terminating Operation of the Release)

PARENT CONSENT:

This authorization is voluntary and remains in effect until the above date or event, unless specifically revoke by written notice to the agency or person. Any information disclosed prior to written revocation of this authorization shall not be a breach of confidentiality. A photocopy of this authorization is as effective as the original. Unless otherwise agreed in writing, information may be disclosed under this authorization in any form or medium, including oral, written, or electronic transmission.

☐ I understand that the student's special education services provided through JRSEU will not be affected if I do not sign this form.

☐ I understand that under the Individuals with Disabilities Education Act, the student's special education services provided through JRSEU may be affected, as specified below, if I do not sign this form.

Specify:

Signature of Parent/Guardian or Custodian (and Relationship):	Date:

☒ **CHECK IF APPLICABLE – NOTICE TO WHOMEVER DISCLOSURE IS MADE CONCERNING EDUCATIONAL AND/OR ADDICTION RECORDS:** This information has been disclosed to you from records protected by Federal confidentiality rules. The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 34 CFR Part 99 and/or CFR Part 2. A general authorization for the disclosure of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

NOTICE: Except for information subject to 34 CFR Part 99 and/or 42 CFR Part 2, information disclosed to another entity may potentially be disclosed, in which case it may not be protected by state or federal law.