RURAL CHAMPAIGN COUNTY SPECIAL EDUCATION COOPERATIVE
807 N. Mattis, Champaign, IL 61821
217-892-8877 FAX: 217-893-8627

Jennifer Armstrong, Executive Director

AUTHORIZATION FOR EXCHANGE OF CONFIDENTIAL INFORMATION

Student Name: Birthdate:

Serving School:

I hereby authorize and request Rural Champaign County Special Education Cooperative to release to:

The following information:

- ☐ Individual Education Program (IEP)
- ☐ Eligibility Determination Conference (EDC)
- ☐ Summary of Contacts
- ☐ Verbal Consultation
- ☐ Education Records
- ☐ Other:
- ☐ Social Development Study
- ☐ Medical History
- ☐ Full Case Study Components
- ☐ Psychological Report

REQUESTED INFORMATION IS TO BE USED FOR COORDINATION OF SERVICES.

I further authorize and request:

To release to: Rural Champaign County Special Education
ATTN:
Address:

The following information:

- ☐ Individual Education Program (IEP)
- ☐ Eligibility Determination Conference (EDC)
- ☐ Summary of Contacts
- ☐ Verbal Consultation
- ☐ Hospitalization Records
- ☐ Other
- ☐ All Medical Records Including Psychiatric, Drug/Alcohol, and Related Records.
- ☐ Social Development Study
- ☐ Medical History
- ☐ Full Case Study Components
- ☐ Psychological Report

REQUESTED INFORMATION IS TO BE USED FOR PLANNING AND/OR COORDINATION OF EDUCATIONAL SERVICES.

I UNDERSTAND THAT THE CONSENT GRANTED BY THIS WRITTEN WAIVER IS VOLUNTARY, AND THAT I MAY WITHDRAW THIS WAIVER AT ANY TIME. I ALSO UNDERSTAND THAT I HAVE THE RIGHT TO INSPECT, COPY AND CHALLENGE SUCH RECORDS IN ACCORDANCE WITH THE ILLINOIS SCHOOL STUDENT RECORDS ACT, 105 ILCS 10/1 ET SEQ., AND THE FAMILY EDUCATION RIGHTS AND PRIVACT ACT, 20 U.S.C. 1283(G), AND TO LIMIT ANY CONSENT GRANTED BY THIS WAIVER TO DESIGNATED RECORDS.

Student Signature (Age 12 or over)

Parent/Guardian/Adult Student (Age 18)

Witness Date/Time

Relationship to Student

Release is valid until:

Date/Time: