

**PERMISSION TO OBTAIN AND RELEASE CONFIDENTIAL INFORMATION**

**REGARDING THE RECORDS OF:**

Name \_\_\_\_\_ D. O. B. \_\_\_\_\_

Address \_\_\_\_\_ Zip \_\_\_\_\_

Parents/Guardian \_\_\_\_\_

**AUTHORIZED AGENT/ORGANIZATION**

Name \_\_\_\_\_ Title \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ Zip \_\_\_\_\_

The undersigned hereby request and authorize the above named agency to exchange records with:

Washington-Caldwell School District  
8937 Big Bend Road  
Waterford, WI 53185  
262-895-7972 Fax: 262-662-9888

The following records may be exchanged:

- Official student academic/achievement records (identifying information, grades, class rank, attendance, achievement/aptitude test results, etc.)
- Medical and/or related health records
- Psychological evaluations, counselor and/or social work reports
- Multidisciplinary/IEP team evaluations and related reports (including evaluations and placement consents)
- Individual Education Plans (IEP)
- Appropriate agency reports
- Other (specify):

The purpose for such disclosure is \_\_\_\_\_.

This permission is valid for one year from the date signed. A copy of this form is effective as the original.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date