

RELEASE OF CONFIDENTIAL INFORMATION

OGLE COUNTY EDUCATIONAL COOPERATIVE

P.O. BOX 582, 417 N. COLFAX ST.
BYRON, IL 61010
TEL. (815)234-2722 FAX (815)234-2938

Re: _____

Birthdate: _____

I give my consent for the exchange of information between the Ogle County Educational Cooperative and

_____ School/Agency/Physician

_____ Street

_____ City

_____ State

_____ Zip

Check one:

Records should be sent to OCEC

Records should be sent from OCEC

Purpose for Disclosure of Information: _____

Nature of Information:

_____ 1) Psychological Evaluation

_____ 6) Physical Therapist Report

_____ 2) Educational Evaluation

_____ 7) I.E.P.s

_____ 3) Speech/Language Evaluation

_____ 8) Case Review/Conferences

_____ 4) Social/Health and Developmental Reports

_____ 9) Teacher Reports

_____ 5) Health Forms (Physical exams & immunization record)

_____ 10) Other _____

Consequences of a Refusal to Consent, if any: _____

As a parent you have the following rights: 1) to inspect and/or receive a copy of the information disclosed; 2) to challenge content of any information released; 3) to limit any information released; and to 4) to rescind this permission at any time upon written request. This authorization expires on _____ (date).

Parent/Guardian Signature: _____

Date: _____

Witness Signature: _____

Student Signature: _____
(if over age 12)

Date: _____

Attention School District: If the above information is not available in your school, please forward this request to the appropriate records clerk of your area special education office.