Appendix A

Alachua County Public Schools
Student Support Services
Interagency Release of Information

Between the Alachua County Public Schools and Outside Agencies/Providers

I, _____, hereby authorize
Full Name

Ages In Motion
Name of Agency and/or Provider

PO Box 357492, Gainesville, FL 32635 352-758-2435
Address City State Zip Telephone

To share/release the information marked below:

About _____ ___/___/___
Student's Full Name Date of Birth

To and From: _____

_____ _____
Address City State Zip Telephone

Please share/release the following records:

- [x] Psychological Evaluation
- [x] Educational Evaluation
- [x] Grades/Educational Tests
- [x] Current Withdrawal Grades
- [ ] Medical Evaluation/health Records
- [x] Other: attendance (absence/tardy); behavior (referrals/suspensions); 504 plans; IEPs
- [ ] Medications
- [ ] Treatment Issues

These records are being shared for the purpose of:
- [x] To assist in the treatment/education program of the student
- [ ] Other

This information is for professional use only and will be handled in a manner to respect and protect confidentiality.

I further understand that I have the privilege of revoking this at any time, providing I submit written notice. However, this will not effect information released prior to revocation.

Your signature on this form authorizes release of the above records. This form shall be valid for [x] one calendar year from the signature date below or [ ] a single disclosure.

_____ _____
Students' Legal Name Parent or Guardian (Signature)

_____ _____
Date of Birth Date

Form No.: STU 213-018 – Interagency Release of Information.doc/STU
New Date: 5/7/13

Distribution: White - Agency
Yellow - School