Clark County School District Las Vegas, Nevada Student Services Division

DATE:	

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Addre	ess:					
l. I	hereby authorize the use or disclosure of the specific info	ormation as described below	v:			
	I authorize release of the following records (description of specific information to be used or disclosed: i.e., medical records, academic records, or entire record). Dates of records: From To					
L III. F	Reasons for use and/or disclosure (i.e., medical care, insurance, personal, attorney, or other specifically described reason):					
IV. <u>F</u>	Persons/Organizations authorized to make disclosure:	Persons/Organizati	ions authorized to use	disclosed information:		
S	School/Organization/Medical Provider	School/Organization/	School/Organization/Medical Provider			
7	Address	Address				
_	Dity State Zip	City	State	Zip		
ii t c ii	I understand that this authorization is voluntary and that I may refuse to sign. I understand that I may inspect or obtain a copy of the information to be used or disclosed. I understand that any medical provider to whom this authorization is furnished may not condition treatment, payment, enrollment or eligibility for benefits on whether or not I sign the authorization. The District will maintain the privacy of student education records pursuant to the provision of the Family Educational Rights and Privacy Act. However, I understand the information used or disclosed under this authorization may be subject to unauthorized redisclosure by the person(s) receiving it and may then no longer be protected.					
	□ I authorize release of these records through facsimile transmission (FAX). I understand and agree that should the records be inadvertently transmitted to an unauthorized recipient, through no fault of the sender, I hereby waive any claim against the sender and agree to hold the sender harmless from any and all responsibility for damages, if any, arising from the faulty transmission.					
	☐ I do not authorize release of records through facsimile transmission (FAX).					
a ir fe	I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writin and present my written revocation to the School in which the authorization was signed. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date If a specific date is not noted, this authorization will expire six months from the date of this request. Please note: The District does not pay for records. If payment is required, please obtain directly from the parent/guardian.					
VII. F	Parent/Guardian Signature:		Date:			
F	Requested by:Name	Title	School			

INSTRUCTIONS:

- 1. ALL SPECIAL EDUCATION RECORDS MUST BE REQUESTED AND/OR SENT THROUGH STUDENT SERVICES.
- 2. Parent, guardian, and/or requesting person are responsible for completion of this authorization.
- 3. The first portion of Section IV should specify the name and the address of the persons/organization holding the records. The second portion should specify the name and address of the persons/organization to which records are to be sent.

USE THIS FORM WHEN: Obtaining information from other organizations, releasing information to other organizations, releasing to parents of 18 year or older student.

