Administrative Unit Name	Date
Brighton 27J School District	

Legal Name of Child/Student ______ Child/Student ID ______ DOB ______

Request to Release or Secure Confidential Information

(Not required for Release to another Administrative Unit)

Records to be Released or Secured:

- ☐ Audiometric
- ☐ Medical (Health)
- ☐ Psychiatric
- ☐ Educational
- ☐ Occupational Therapy
- ☐ Psychological
- ☐ Speech/Language
- ☐ Physical Therapy
- ☐ Social Work
- ☐ IEP
- ☐ Other (Specify) ______

	From	**To**
Agency		
Address		
City, State, Zip		

All information released or secured will be in compliance with the Family Education Rights and Privacy Act and the Colorado Open Records Law. No additional information will be released or secured without prior approval from the parent, except as provided by law.

PARENTAL CONSENT

(Please return this form in the enclosed self-addressed, stamped envelope.)

I hereby authorize the transfer of information as stipulated above **Yes** ☐ **No** ☐

______
Signature of Parent(s) **Date**

______
Signature of Parent(s) **Date**

Nov - 2004