



# McLean County Public Schools

## Consent for Exchange of Information and Release of Records

410 KY 136 E  
P.O. Box 245  
Calhoun, KY 42327

Terence Hayes  
Superintendent  
Phone: (270) 273-5257  
Fax: (270) 273-5259

I, \_\_\_\_\_, give my consent for the following persons/agencies to release/exchange information and confidential records concerning:

_____	_____	_____
Name of Student/Person	Date of Birth	Social Security Number
_____	_____	_____
Address		Relationship to Person

**Releasing Persons/Agencies:**

Name _____	Name _____
Address _____	Address _____
_____	_____

**Information Requested:**

<input type="checkbox"/> Medical Records	<input type="checkbox"/> Statement of Legal Status/Custody
<input type="checkbox"/> Psychiatric/Psychological Evaluation Results	<input type="checkbox"/> Treatment Plan/Medications
<input type="checkbox"/> Inpatient Records/Discharge Summary	<input type="checkbox"/> Physical Exam
<input type="checkbox"/> Special Education Records	<input type="checkbox"/> Behavioral Charts/Schedule
<input type="checkbox"/> Student Cumulative Records	<input type="checkbox"/> Diagnosis
<input type="checkbox"/> Developmental/Psychosocial History	<input type="checkbox"/> Other _____
<input type="checkbox"/> Number of Kept/Unkempt Appointments	<input type="checkbox"/> Other _____

**The above requested information is requested for the purpose of:**

<input type="checkbox"/> Educational Planning	<input type="checkbox"/> Supplement Referral Information
<input type="checkbox"/> IEP Development	<input type="checkbox"/> Completion of Developmental/Psychosocial
<input type="checkbox"/> Collaboration with Medical Staff	<input type="checkbox"/> Section 504 Referral/Review
<input type="checkbox"/> Collaboration with Mental Health Staff	<input type="checkbox"/> Other _____

I understand that the release of the above records or the exchange of confidential information/records are protected under State and Federal Confidentiality Regulations and the Family Educational Rights and Privacy Act of 1974 and therefore cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time, except to the extent that actions (release/exchange) have already been taken. **Attention persons/agencies receiving records:** The information being disclosed to you is protected by Federal Conventionality Rules (42 CFR Part 2). This Federal rule prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to who it pertains or parent/guardian of that person.

_____	_____	_____
Signature of Parent/Guardian	Date Signed	Date Consent Expires (not to exceed 1 year)
_____	_____	_____
Signature of Person/Client (If Applicable)	Date Signed	Signature of Witness

**Please send the above requested information to:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_