



JOHNSTON PUBLIC SCHOOLS
 ADMINISTRATION OFFICE
 10 MEMORIAL AVENUE
 JOHNSTON, RHODE ISLAND 02919-3222

OFFICE OF SPECIAL SERVICES
RELEASE OF RECORDS FORM

STUDENT (PLEASE PRINT): _____ D.O.B.: ____/____/____
 SCHOOL: _____ GRADE: _____ TEACHER/COUNSELOR: _____
 PARENT/GUARDIAN: _____ ADDRESS: _____
 TELEPHONE: (h) _____ (w) _____ (c) _____

Authorization for the Johnston Public Schools to:

_____ *Release to* or _____ *Obtain from* and _____ *Verbal exchange with*
PERSON/AGENCY: _____
ADDRESS: _____

confidential information regarding the above-named student.

Records to be released/disclosed:*

_____ All records used to determine eligibility for special education and/or related services
 _____ Psychological _____ Educational _____ Psychiatric/Clinical Psychological
 _____ Social History _____ Speech/Language _____ Medical
 _____ IEP _____ Early Child. Dev. Assess. _____ Other: _____

The purpose of release/disclosure is:

_____ to assist in educational planning _____ to assist in transfer to a new school district*
 _____ to share evaluation/re-evaluation results _____ to plan for transition
 _____ at the request of the parent/guardian _____ other: _____

Please check below:

_____ I have been fully informed and understand the school's request for my consent, as described above. This information will be released/disclosed upon receipt of my written consent.
 _____ I understand that my consent is voluntary and may be revoked at any time. However, I understand that revocation is not retroactive (i.e., it does not negate an action that occurred after the consent was given and before the consent was revoked).
 _____ I give my permission for the identified records to be released/disclosed to the above-named person/agency.

DATE: _____ This release is valid from: ____/____/____ to ____/____/____

 SIGNATURE OF PARENT/GUARDIAN

 SIGNATURE OF WITNESS

 SIGNATURE OF STUDENT (18 YEARS OR OLDER)

* Parent authorization is not required to transfer educational records to another school district.