Authorization for Mutual Exchange of Confidential Information

Student Name: _____ **Birthdate**: _____

School: _____ **Grade:** _____ **Date:** _____

As a Parent(s) / Guardian (s) of the above named student, I hereby authorize the mutual exchange of information between Centralia School District and the following (list all relevant schools, physicians, psychologists, hospitals, clinics, etc. that have, or have had, significant contact with your child):

Name	Address / Phone
_____	_____
_____	_____
_____	_____
_____	_____

This authorization is valid for one year from the date of signing.

In accordance with the requirements of the Family Educational Rights and Privacy Act of 1974, I hereby acknowledge notification that the records of the above named student are to be transmitted to / from Centralia School District. I have been notified of my rights to inspect the records, request a copy of the records at my expense, and to have a conference to remove or correct any information that is inaccurate, misleading, or otherwise violates the student's right to privacy, or other rights.

Information sent or received by the Centralia School District may not be shared with any other party without the written consent of the parents or guardians, or the student, if eighteen (18) years old or older.

This authorization releases the Centralia School District and employees thereof from any indemnity arising from the release of confidential information.

Reason for Release: _____

_____

Person Making Request: _____

_____

_____	_____
Signature(s) of Parent(s) / Guardian(s)	**Signature(s) of Parent(s) / Guardian(s)**
_____	_____
Date	**Date**