

EXHIBIT 1.1: SAMPLE RELEASE OF RECORDS FORM

INTERAGENCY RELEASE OF INFORMATION

By signing and dating this release of information, I allow the persons or agencies listed below to share specific information, as checked, about my case. I understand that this is a cooperative effort by agencies involved to share information that will lead to better utilization of community resources and better cooperation amongst our agencies to best meet my needs.

Agencies or agency representatives that will be sharing information:

Name	Address	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

The information is to be released is: _____ History _____ Lab Work
_____ Diagnosis _____ Psychological Assessment
_____ Summary of Treatment _____ Psychiatric Evaluation
_____ Medications _____ Legal issues/concerns
_____ School Evaluation _____ Performance
_____ Other (specify) _____

and is to be released for the purpose of _____.

This consent to release is valid for one year, or until otherwise specified, and thereafter is invalid. Specify date, event, or condition on which permission will expire: _____

I understand that at any time between the time of signing and the expiration date listed above I have the right to revoke this consent.

Student Name Date of Birth

Address City State Zip Code

Student Signature Date Witness Date

Guardian or Responsible Party Date Witness Position
(if student is under legal age)

Guardian/Responsible Party Relationship to Student Sample contributed by Flint Hills Special Education Cooperative