SWEETWATER COUNTY
SCHOOL DISTRICT NUMBER ONE

AUTHORIZATION FOR EXCHANGE OF CONFIDENTIAL INFORMATION

In accordance with the requirements of the Family Education Rights and Privacy Act of 1974, confidential information on youths under 18 years of age may not be shared with any other party without the written consent of the parent or guardian.

As parent/guardian of the following student(s) or as a student who has attained the age of majority, I hereby authorize the exchange of confidential information between the parties identified below. I understand this authorization may be revoked at any time.

Name of Pupil	Birth Date	School Attended	Grade
_____	_____	_____	_____
_____	_____	_____	_____

RECORDS TO BE RELEASED:

[ ] FROM* or [ ] TO

_____
_____
_____
_____

Phone #: _____

Fax #: _____
*Please return a copy of this release with your records.

[ ] FROM or [ ] TO

SEND ALL RECORDS TO:
Attn: _____
School: _____
Sweetwater County SD #1
P.O. Box 1089
Rock Springs, WY 82902-1089

PHONE: 307-352-3235
FAX: 307- 352-3241

Records Requested:
[ ] Most recent IEP
[ ] Most current evaluation/test results
[ ] Counseling Information
[ ] Other:

[ ] Medical Information
[ ] Discharge Summary
[ ] Psychiatric/Psychological test results
[ ] Treatment Recommendations

Person requesting information:

School: _____
Phone: _____

Purpose:
[ ] To develop appropriate educational plan
[ ] Other:

_____
Parent/Guardian or Adult Student Signature

_____
Witness

_____
Date

_____
Date

A copy of this Release is as good as the original