PARENT/GUARDIAN/STUDENT CONSENT FOR RECORDS RELEASE

Putnam County Educational Service Center
124 Putnam Parkway
Ottawa, Ohio 45875
419-523-5951

Name of Student: _____ Date of Birth: _____ Age: _____

TO:

_____ _____
Agency/Hospital/Physician, etc. Attention To/Name

_____ _____
Street Address City, State, Zip

_____ _____
Phone Number Fax Number

We are requesting the following information/records for the above-named student:
(please check):

θ The following educational or medical records only: (please be specific)

_____

_____

Reason for request: (please check)

θ To aid in making present and future educational decisions.

θ Other: (please specify)

_____

YOU MAY EXCHANGE INFORMATION WITH OR SEND INFORMATION TO:

_____ _____
School District/Agency Name

_____ _____
Street Address City, State, Zip Code

This authorization must be signed and dated, and may be revoked at any time except to the extent action has been taken prior to the revocation. Revocation must be made in writing. I hereby state that I have read and fully understand the above statements as they apply to my child. I understand that enrollment and/or eligibility for services, are not conditional based upon signing this authorization.
I hereby authorize to the disclosure of medical/educational records for the purpose stated above. I understand that, once released, these records are not protected by the hospital/physician/health care/educational provider and may be subject to being disclosed by the party who received these records.

_____
Signature of parent/guardian or student, if 18 or older

_____
Date

Consent will expire: _____
(Date)

I hereby revoke the authorization for releasing of information regarding my child.

_____
Signature of parent/guardian Date

Rev. 5/2012