

Alachua County Public Schools  
Student Support Services  
**Interagency Release of Information**

Between the Alachua County Public Schools and Outside Agencies/Providers

I, \_\_\_\_\_, hereby authorize

Full Name

\_\_\_\_\_  
Name of Agency and/or Provider

\_\_\_\_\_  
Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

\_\_\_\_\_  
Telephone

To share/release the information marked below:

About \_\_\_\_\_

Student's Full Name

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date of Birth

To and From: \_\_\_\_\_

\_\_\_\_\_  
Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

\_\_\_\_\_  
Telephone

**Please share/release the following records:**

- |  |  |
|--|--|
| <input type="checkbox"/> Psychological Evaluation          | <input type="checkbox"/> Educational Evaluation    |
| <input type="checkbox"/> Grades/Educational Tests          | <input type="checkbox"/> Current Withdrawal Grades |
| <input type="checkbox"/> Medical Evaluation/health Records | <input type="checkbox"/> Other: _____              |
| <input type="checkbox"/> Medications                       | <input type="checkbox"/> Treatment Issues          |

This information is for professional use only and will be handled in a manner to respect and protect confidentiality.

I further understand that I have the privilege of revoking this at any time, providing I submit written notice. However, this will not effect information released prior to revocation.

\_\_\_\_\_  
Students' Legal Name

\_\_\_\_\_  
Parent or Guardian (Signature)

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Date