Shiawassee
Regional Education Service District

1025 N. Shiawassee Street
Corunna, Michigan 48817
(989) 743-3471

CONSENT FOR ACCESS TO STUDENT RECORDS

This consent must be signed by a parent or guardian of a minor student or by the student if eighteen years of age or older or a legally emancipated minor.

Date: _____

Name of Student: _____ Birthdate: _____

Name of Person Giving Consent: _____ Relationship to Student:_____

Address: _____

This access to student records will allow:

☐ First Party/Agency information released only to Second Party/Agency.

☐ Mutual sharing of described information between both Parties/Agencies on a continuing basis.

PERSON(S) TO WHOM THE RECORDS MAY BE DISCLOSED (by name or description if more than one person):

_____

WHAT RECORDS MAY BE DISCLOSED?

☐ Educational, medical or mental health records, including: _____

_____

☐ Substance abuse information

☐ Information regarding serious communicable diseases or infections, such as AIDS, TB, or Hepatitis.

☐ Other: _____

FOR WHAT PURPOSE MAY THESE RECORDS BE USED BY THE PERSON TO WHOM THEY ARE DISCLOSED? *

_____

EXPIRATION DATE OR EVENT? _____

Revocation of this consent may be made in writing to:

Assistant Superintendent for Special Education
Shiawassee Regional Education Service District
1025 N. Shiawassee Street
Corunna, Michigan 48817

* Shiawassee RESD policy requires that information released be utilized only for the purposes for which they are specifically disclosed. Confidential information will not be re-disclosed without written authorization.

I hereby consent to the disclosure of records described above.

Signed: _____ Date: _____

Reply attention to: _____

First Party/Agency: _____

1st Copy: Address: _____

_____

Second Party/Agency: _____

2nd Copy: Address: _____

_____