WILLIAMSON COUNTY
Special Education District

B7

CONSENT FOR RELEASE OF INFORMATION

Re:_____ _____
(Student Name) (Birthdate)

_____
(Address) (County) (Parent/Guardian)

I authorize the Williamson County Special Education District to release/obtain the following oral and written information to/from:_____

	Release	Obtain			Release	Obtain	
1.	[ ]	[ ]	Psych.Reports	5.	[ ]	[ ]	Social Service Info.
2.	[ ]	[ ]	Medical Reports	6.	[ ]	[ ]	School Reports (IEP,MDC)
3.	[ ]	[ ]	Speech/Language/Aud.	7.	[ ]	[ ]	Vocational Records
4.	[ ]	[ ]	PT/OT Reports	8.	[ ]	[ ]	Other
				9.	[ ]	[ ]	Exceptions (Do not send)

This information is needed for the following purpose (s):_____

Send information to:
Williamson Co. Special Education Dist.
MICKI FOWLER, Records Custodian
411 South Court Street
Marion, IL 62959

Mrs. Micki Fowler, Records Custodian
micki.fowler@wces.co

I understand that the consent granted by this written waiver is voluntary, and that I may withdraw this waiver at any time. I also understand that I have the right to inspect, copy and challenge such records in accordance with the Illinois School Student Records Act, 105 ILCS 10/1 et seq., and the Family Education Rights and Privacy Act, 20 U.S.C. §1283(g), and to limit any consent granted by this waiver to designated records.

_____ _____
Student Signature (Age 12 or over) **Parent/Guardian/Adult Student (Age 18)**

_____ _____
Witness Signature - Date/Time **Relationship to Student**

Release is valid until: _____ **Date/Time:** _____