RECORDS RELEASE
ACT GA, INC.

SPECIAL EDUCATION ADVOCACY SERVICES

AUTHORIZATION FOR RELEASE OF RECORDS

STUDENT NAME:____ DATE OF BIRTH:____________

CURRENT GRADE:______ SCHOOL NAME:__________________________ DISTRICT:____________

STUDENT'S MAILING ADDRESS:____

____

PARENT(S)/GUARDIAN(S) NAME(S): ____

PHONE:____________________ EMAIL: ____

AUTHORIZATION

I, THE UNDERSIGNED PARENT/LEGAL GUARDIAN OF THE ABOVE-NAMED STUDENT, HEREBY AUTHORIZE ACT GA, INC. AND ITS REPRESENTATIVES TO:

1. ACCESS RECORDS: REQUEST, OBTAIN, REVIEW, AND RECEIVE COPIES OF ALL RELEVANT RECORDS, INCLUDING BUT NOT LIMITED TO:

- EDUCATIONAL RECORDS (INCLUDING IEPS, 504 PLANS, EVALUATIONS, PROGRESS REPORTS, DISCIPLINARY RECORDS, ATTENDANCE RECORDS, AND CORRESPONDENCE)
- PSYCHOLOGICAL AND BEHAVIORAL EVALUATIONS
- OCCUPATIONAL THERAPY, SPEECH/LANGUAGE, AND OTHER RELATED SERVICE RECORDS
- MEDICAL RECORDS RELEVANT TO THE STUDENT'S EDUCATIONAL NEEDS
- ANY OTHER RECORDS NECESSARY TO SUPPORT ADVOCACY EFFORTS

THIS AUTHORIZATION IS GRANTED IN ACCORDANCE WITH:
THE FAMILY EDUCATIONAL RIGHTS AND PRIVACY ACT (FERPA)
THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

2. COMMUNICATION WITH PROVIDERS: ACT GA, INC. AND ITS REPRESENTATIVES MAY COMMUNICATE DIRECTLY WITH:

- SCHOOL DISTRICT STAFF AND ADMINISTRATORS
- TEACHERS AND SERVICE PROVIDERS
- MEDICAL AND MENTAL HEALTH PROVIDERS
- EVALUATORS AND SPECIALISTS

FOR THE PURPOSE OF GATHERING INFORMATION AND SUPPORTING THE STUDENT'S NEEDS.

BY SIGNING THIS DOCUMENT, I HEREBY DECLARE THAT I UNDERSTAND AND ACKNOWLEDGE THAT I AM GIVING AUTHORIZATION TO THE USE AND/OR DISCLOSURE OF MY STUDENTS INFORMATION AS DESCRIBED AND FOR THE PURPOSE SPECIFIED ABOVE.

I AM SIGNING THIS AUTHORIZATION VOLUNTARILY. I UNDERSTAND THAT I HAVE THE RIGHT TO WITHDRAW MY PERMISSION OR WITHDRAW MY AUTHORIZATION AT ANY TIME BY WRITING.

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PRINTED NAME OF PARENT/GUARDIAN **DATE**

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SIGNATURE