Request to Release or Secure Confidential Records
(Not required for Release to another Administrative Unit)

_____ _____ _____ _____
Legal Name of Student SASID Grade DOB

_____ _____
School of Attendance Date of IEP Meeting

❑ Educational (specify) ❑ Medical (specify) ❑ Special Education (specify)
_____ _____ _____
_____ _____ _____
_____ _____ _____

❑ Other _____

Agency From:	**Agency To:**
Agency:	Agency:
Name:	Name:
Phone:	Phone:
Address:	Address:
City:	City:
State:	State:
Zip:	Zip:

All information released or secured will be in compliance with the Family Education Rights and Privacy Act and the Colorado Open Records Law. No additional information will be released or secured without prior approval from the parent, except as provided by law.

PARENTAL CONSENT
(Please return this form in the enclosed self-addressed, stamped envelope.)

I hereby authorize the transfer of information as stipulated above. ☐ Yes ☐ No

_____
Signature of Parent/Legal Guardian(s) Date

_____
Signature of Parent/Legal Guardian(s) Date

Revised May 20, 2009