LIVONIA PUBLIC SCHOOLS
DEPARTMENT OF STUDENT SERVICES

RELEASE OF INFORMATION/AUTHORIZATION
FOR DISCLOSURE OF INFORMATION

Student Information:

Name _____ Address _____

Birthdate _____ _____

School/Grade _____ Telephone _____

I authorize the Livonia Public Schools School District to release/request information in my records to/from:

Please check: ☒ *release* *and/or* ☒ *request*

Name _____ Agency/School _____

Address _____

Phone _____ Fax No. _____

Please check specific information to be released/requested:

- X Medical Information
- _____ Transcripts
- _____ Report Cards
- _____ Psychological Reports/Evaluations
- _____ Psychiatric Evaluations
- _____ IEP, MET, and Evaluation Reviews
- _____ Social Work Report/Evaluation
- _____ Intake and Discharge Summary
- _____ Teacher/Counselor reports
- _____ Referrals
- _____ Phone calls
- _____ Assessment Data
- _____ Attendance
- _____ Speech/Language Evaluation
- _____ Disciplinary Record

_____ Other _____

_____

If sending identified information to Livonia Public Schools, please send to:

Department of Student Services
Livonia Public Schools
15125 Farmington Road
Livonia, Michigan 48154
Phone No. 734-744-2615
Fax No. 734-744-2611

Attention: Director of Student Services

_____
Person(s) Requesting Records

The Purpose and Need for Such Release/Request: ☐ Educational Planning ☐ Grade Placement

☐ Disciplinary Information ☐ Credit/Course Determination ☒ Other Individual Health Care Plan

This authorization will expire in one calendar year.

NOTE: Information will be forwarded to appropriate school personnel

☆ Signature of Parent/Guardian _____ ☆ Date _____

Department of Student Services Office Use Only: Date information forwarded to requesting person. _____

By Whom_____

Original - Student Services
Copies - Parent/Student
- Agency
- School