

MORTON COMMUNITY UNIT SCHOOL DISTRICT #709

Morton, IL 61550

Current Date _____

I give my permission for Morton CUSD 709 to secure from

(Name of School, Agency, or Person)

(Address)

Information regarding: _____
(Student Name) (Date of Birth)

Release to Secure from

_____	_____	Verbal Exchange of Information
_____	_____	Regular Division Student Records
_____	_____	Academic Records
_____	_____	Health & Medical Records
_____	_____	Psychological Reports - Initial Eval and Reevals
_____	_____	Social Developmental Reports Initial Eval and Reevals
_____	_____	Speech & Language Reports Initial Eval and Reevals
_____	_____	Occupational Therapy Reports Initial Eval and Reevals
_____	_____	Other - any other pertinent information

I understand that I have the right to review and possibly challenge such records before they are released, and:

1. _____ I hereby **waive** that right
2. _____ I hereby **request** an appointment to review and/or challenge the records
(form DF 15k should be completed)
3. _____ I wish to receive a copy of the records

(Signed: Parent/Guardian/Self)

(Address)

Please send records to:

Special Education Office
1050 S. Fourth St., Ste. 100
Morton, IL 61550

Phone: (309)263-0522
Fax: (309)284-8015

Person requesting information: _____
(Request remains valid for 360 days) (Signature) (Title)