I understand that these records are protected under Federal and State confidentiality regulations and cannot be released without written consent, unless otherwise provided for in the regulations.

Federal regulations prohibit further disclosure of the records without specific written consent or as otherwise permitted by such regulations. I understand that this consent expires one year from the date of the signature, or I may revoke this consent in writing at any time (unless action has already been taken based upon this consent).

AUTHORIZING PERSON: □ Parent □ Guardian □ Legal Custodian □ Other	er	
I authorize the release of information regarding		
NAME OF CHILD	DATE OF BIRTH	
and I authorize the person(s) or agency listed below to release information to the authorized third-party mediator. Information provided will include records maintained in the child's educational file, which may include information submitted by the requesting party and confidential or medical information for the purpose of providing mediation.		
SPECIAL EDUCATION RESOLUTION CENTER (SI Oklahoma State University 9726 E. 42nd Street, Suite 203 Tulsa, OK 74146 (918-270-1849)	ERC)	
AND		_ SOONERSTART SITE
ADDRESS	CITY	ZIP CODE
If the records to be disclosed are education record accordance with the Family Educational Rights a provided with a copy of the record(s) to be discloprior consent of parents. The information I author	and Privacy Act (Fl sed if requested. F	ERPA). Parents shall be Redisclosure requires

noncommunicable disease, which may include, but are not limited to, diseases such as Hepatitis, Syphilis, Gonorrhea and the Human Immunodeficiency Virus (HIV), also known

DATE



as Acquired Immune Deficiency Syndrome (AIDS).

and record(s) which may indicate the presence of a communicable or

