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 regulation. 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:

☐ Young Adult ☐ Parent ☐ Guardian ☐ Legal Custodian ☐ Other _____

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 any and all information known or maintained in the child's educational file and which may include information submitted by the requesting party, any educational records including confidential information, any medical and any psychological records for the purpose of providing mediation.

Special Education Resolution Center (SERC),
Oklahoma State University,
9726 E. 42nd Street, Suite 203
Tulsa, OK 74146
(918-270-1849)
and _____
(School District)

_____ _____ _____
(Address)   (City)   (Zip Code)

If the records to be disclosed are education records (which my include discipline records), they are maintained and released in accordance with the Family Educational Rights and Privacy Act (FERPA). Parents or eligible students shall be provided a copy of the records to be disclosed if requested. Redisclosure, except as provided at 34 CFR §99.31, requires prior consent of parents or eligible students.

The information I authorize for release may include information and records which may indicate the presence of a communicable or noncommunicable disease, which may include, but are not limited to, diseases such as Hepatitis, Syphilis, Gonorrhea and the Human Immunodeficiency Virus (HIV), also know as Acquired Immune Deficiency Syndrome (AIDS).

_____ _____
Signature of person authorizing release   Date