GILBERT PUBLIC SCHOOLS

140 S. Gilbert Road, Gilbert, AZ 85296

AUTHORIZATION FOR THE RELEASE OF PSYCHOLOGICAL/SPECIAL EDUCATION INFORMATION

Student Name:	Date of Birth:

I, _____ ☐ PARENT/LEGAL GUARDIAN ☐ STUDENT (IF OVER 18)
Print Name

Please release a copy of the special education records as indicated:

☐ Current IEP ☐ Evaluation (MET) ☐ Other: _____

Please deliver the documents by the following method:

☐ Email: _____ ☐ Fax: _____

☐ Pick up in Person - I can be reached at _____when documents are available

☐ U.S. Mail: _____

OR

I authorize the release of records to the following school or agency:

_____
Name of School/Agency

_____
Street Address City State Zip

_____
Email Fax

_____ _____
Signature *Date*

Signature and Photo ID Are Required For Records To Be Released

For Office Use Only

Received By: _____ Photo ID Verified: _____/_____/_____

Records Sent: _____/_____/_____