
DISTRICT STUDENT REQUEST FOR RECORDS



Please send any records that you may have for _____
who has been enrolled at _____ Southgate Community School District to:

Last School Attended Information:

District _____
School Name _____
Street _____
City _____
State, Zip _____

School Contact Information:

Contact Person Name _____
Telephone Number _____
Fax Number _____

Please Include the Following Records:

- Cumulative Record
- Michigan UIC Code
- Attendance Record
- Standardized Test Results-Michigan MEA & MME
- Student Portfolio Material, EDP (if available)
- Grade Transcript (including grades at time of withdrawal and explanation of grading system)

Thank you.

Parental permission is no longer required when records are requested by authorized school personnel in compliance with "Federal Education Rights & Privacy Act. Final rule on Educational Records, Federal Register, June 17, 1976, Volume 41. No 118, Page 4875".

Notice: Attorney General Opinion a6064 states: ... a school district must furnish the records of a student upon request of another school district in which the student is enrolled.. and is precluded from withholding the records because the student or his or her parent are indebted to the school district possessing the records for fees or other changes."

SOUTHGATE COMMUNITY SCHOOL DISTRICT
DEPARTMENT OF SPECIAL SERVICES

AUTHORIZATION TO RELEASE INFORMATION

Name _____ Date of Birth _____

Address _____
Street City State Zip

I authorize the Southgate Community School District to disclose/request information in my records to/from:

Name of Individual or Facility

Address of Individual or Facility

Telephone

Check Specific Information to be Released/Requested:

- | | |
|---|---|
| <input checked="" type="checkbox"/> Psychological Testing | <input type="checkbox"/> Intake and Discharge Summary |
| <input checked="" type="checkbox"/> Academic Testing | <input type="checkbox"/> Psychiatric Evaluations |
| <input checked="" type="checkbox"/> Speech and Language Testing | <input type="checkbox"/> Medical Test Reports |
| <input checked="" type="checkbox"/> Social Work Evaluation | <input type="checkbox"/> Other _____ |
| <input checked="" type="checkbox"/> IEP, MET, Evaluation Review | <input type="checkbox"/> Other _____ |

The Purpose and Need for Such Disclosure/Request: Educational Placement

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing to the Department of Special Services. Information may have already been released based on this original authorization. We will not release any additional information after we receive your revocation. We will not condition treatment or payment based on this authorization unless otherwise allowed by law.

The requested information will be disclosed as provided by this authorization. This information may be subject to re-disclosure by the recipient and may no longer be protected. This authorization will expire in 90 days from the date set forth below, or for the following specified reasons:

Condition: _____ Date: _____ Event: _____

Client/Parent/Guardian Signature

Date

Witness

Date

A PHOTO COPY OR FACSIMILE OF THIS AUTHORIZATION WILL BE
CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL

12601 McCann
Southgate, MI 48195
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