DISTRICT STUDENT REQUEST FOR RECORDS

Southgate Community Schools

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:

- ☒ Psychological Testing
- ☒ Academic Testing
- ☒ Speech and Language Testing
- ☒ Social Work Evaluation
- ☒ IEP, MET, Evaluation Review
- ☐ Intake and Discharge Summary
- ☐ Psychiatric Evaluations
- ☐ Medical Test Reports
- ☐ Other _____
- ☐ 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
734.246.4619 Fax 734.284.4476