



## DCPS Authorization for Release of Education Records

I, Parent of /Adult Student , \_\_\_\_\_ hereby give my  
**(PRINT STUDENT'S NAME AND DATE OF BIRTH)**

consent to my student's/my school or other DCPS officials to release the records identified below to:

\_\_\_\_\_  
(Name of representative, agency, physician, or attorney)

\_\_\_\_\_  
(Address and phone number of representative, agency, physician, or attorney)

The purpose of the disclosure is:  
\_\_\_\_\_

\_\_\_\_\_  
(Describe the specific purpose for the records disclosure)

By signing below, I authorize the release of the following records:  
\_\_\_\_\_

\_\_\_\_\_  
(Describe specifically which records are to be released including any applicable date range)

By signing below, **1) I acknowledge and understand that I have the opportunity to review the records to be disclosed and the right to challenge the contents of such records;** and 2) I am signing this document on behalf of my child because he/she is not 18 years of age **OR** I am signing as an adult student because I am at least 18 years of age and hold my educational rights.

NOTE: This release is valid only for the purposes stated above. DCPS must obtain my written authorization before sharing education records in a manner that differs from any of the information provided in this consent form. **If signed by an adult student, this authorization will expire one year from the date of signature. If signed by a parent, this authorization will expire one year from the date of signature or when the student reaches 18 years of age, whichever is sooner.**

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Parent/Adult Student Signature)

\_\_\_\_\_  
(Parent/Adult Student contact number)

\_\_\_\_\_  
(Parent/Adult Student Current address)