THE SCHOOL BOARD OF BROWARD COUNTY, FLORIDA

AUTHORIZATION FOR RELEASE AND/OR REQUEST FOR INFORMATION

I hereby request and authorize: McFatter Technical College
(Name of Person, School, or Department)

6500 Nova Drive (Street Address) Davie, Fl 33317 (City) (State) (Zip) 754-321-5700 (Telephone #) to engage

in verbal and/or written communication with and release records to : _____
(Name of Person, Job Title and/or School/Agency/Entity)

_____
(Street Address) (City) (State) (Zip) (Telephone #)

regarding the **information checked below** concerning my child* _____, whose date of birth is _____. I understand that information concerning psychiatric, psychological, medical diagnosis, drug or alcohol abuse, economic status, and educational information regarding my child will be released and/or communicated if indicated below. I further understand that this information might contain information regarding my family, in addition to my child.

- ☐ Treatment Plans
- ☐ Treatment / Discharge Summaries
- ☐ Health / Medical Records
- ☐ Case / Progress / Therapy Notes

Academic / School-related Records:

- ☐ Grades
- ☐ Test Scores
- ☐ Attendance
- ☐ Suspensions / Expulsions
- ☐ Other _____

- ☐ Exceptional Student Education / Section 504 records
- ☐ Substance Abuse Treatment Records
- ☐ Social and/or Developmental History
- ☐ Psychological and/or Psychiatric Evaluations
- ☐ Restorative Support Services
- ☐ Social Support Services (Food, Clothing, Shelter)
- ☐ Medical Services
- ☐ HIV/AIDS test results or related conditions (to disclose or receive this information, specific individuals must be named above)

For the Purpose of: Educational Purposes

I acknowledge that all information I authorize to be released or requested will be held strictly confidential and cannot be released by the recipient without an additional written consent. I understand this authorization will expire one (1) year after the date signed, or on _____, 20 23 , whichever is earlier. A copy of this authorization is valid in lieu of the original. I further understand I may withdraw my consent in writing at any time.

_____ _____ _____
Print Name of Parent / Guardian / *Eligible Student Signature of Parent / Guardian / *Eligible Student Date

_____
Relationship to Child

*Eligible students (age 18 or over) may authorize the release of their education records.

(USE THIS SPACE IF CONSENT IS WITHDRAWN)
I hereby withdraw my previous consent to the release of information about my child.

_____ _____
Date Consent Is Withdrawn Signature of Parent / Guardian / *Eligible Student

Form #4301/ rev 4/15/18
Risk Management