Champaign Community Unit District No. 4 Schools
Family Information Center
1103 North Neil Street – Champaign, IL 61820
Phone (217) 351-3701 – Fax (217) 373-7315

AUTHORIZATION FOR RELEASE/EXCHANGE OF CONFIDENTIAL INFORMATION

NAME OF STUDENT: _____ BIRTHDATE: _____

ADDRESS: _____

CURRENT GRADE LEVEL: _____ TELEPHONE: _____

As the parent or legal guardian of the above named child, I hereby grant my permission to the Champaign Community Schools to release/exchange all records concerning the above named student (please check below):

☐ Scholastic ☐ Health ☐ Psychological Other: _____

_____ _____
(Former School Name) (Address)

Phone: _____ Fax: _____

I understand that my permission covers the release/exchange of permanent and temporary records, as well as the release/exchange of confidential records and reports. I also understand that I have the right to inspect and copy school records, to challenge the contents of these records and /or limit this consent to specific records or portions of records which I have designated above. In addition, I understand I have the right to request a hearing to determine the status of such information and that, at any time during the period of permission granted, I may revoke this permission.

Please send these records to:

_____ _____
Signature of Parent/Guardian or Adult Student Over Age 18 Date