

TEMPE UNION HIGH SCHOOL DISTRICT

SPECIAL EDUCATION

500 W. Guadalupe Rd.

Tempe, AZ 85283

Phone (480) 839-0292

Fax (480) 345-3775

AUTHORIZATION FOR RELEASE OF STUDENT SPECIAL EDUCATION RECORDS

School: THS MHS MDN CDS MTP DV CHS

Student's Name _____ Date of Birth: _____

Release to: Vocational Rehabilitation - 125 E. Elliot Rd., Chandler, AZ 85226

City State

I hereby authorize the Tempe Union High School District, Special Education Office, to release student records of the above-named student to the third party(ies) identified herein for the purpose of formulating the most appropriate plan for the education of the above-named student. The CONFIDENTIAL NATURE of these records will be maintained.

The following records may be released:

- Entire File
- Psychoeducational Evaluation Report
- Individual Education Program (IEP)
- Developmental/Social History
- Physician Signed Medical Certification Statement(s) for (A), (HI), (OHI), (OI), (TBI), (VI)
- School Transcript/Academic History
- Speech/Physical/Occupational Therapy Evaluation(s)
- 504 Plan
- Other

Any of the above records may be released to Arizona Health Care Costs Containment System (AHCCCS) and PCG should my child, named above, be eligible or become eligible in the future for AHCCCS benefits (Medicaid Health Coverage). I understand that the school district may receive partial reimbursement and will in no way affect any maximum benefit limits of the individual student receiving Medicaid Benefits from AHCCCS.

Parent/Guardian Signature (or Student if 18 years of age or older)

Address _____

City _____ State _____ Zip _____

Telephone _____

Date _____