

**CONSENT TO SHARE EARLY INTERVENTION RECORDS AND INFORMATION**  
**Family Educational Rights and Privacy Act, 34 C.F.R. § 99.30**  
**Individuals with Disabilities Education Act, 34 C.F.R. §§ 303.414 & 303.420**

Name of person/organization disclosing information\*: \_\_\_\_\_

**Name and date of birth of individual/client whose specific information is being disclosed:**

Child's Name\*: \_\_\_\_\_ Date of Birth\*: \_\_\_\_\_

**Name and contact information of the person receiving the information:**

Name of Person/Organization Receiving Information\*: \_\_\_\_\_

Contact Information (*Where records can be sent? Email, Fax, or Mailing Address*)\*: \_\_\_\_\_

**Describe the specific purpose of this release\*:**

Litigation

**Information to be Disclosed (*select one*)\*:**

Specific information to be disclosed (*please describe specific information to be disclosed*):

Any and all education records concerning the client listed above in DES AZEIP's possession, including but not limited to: any education records protected by the Family Educational Rights and Privacy Act as defined in 20 U.S.C. § 1232g(a)(4) and 34 C.F.R. § 99.3 and the Individuals with Disabilities Education Act as defined in 34 C.F.R. § 303.414(b)(2)(ii).

Billing records are not considered part of the child's education record and maintained separately. If you would like billing records, please select this option.

**Redisclosure Provisions (*select one*):**

I understand that once the education records and information authorized herein are disclosed to: \_\_\_\_\_ they cannot be redisclosed without the prior consent of the parent; or

I consent to redisclosure of education records by the recipient for use in litigation (*this could include disclosure to a court, lawyers, parties, expert witnesses, trial consultants, etc.*)

I consent to redisclosure of education records by \_\_\_\_\_ as follows:

\_\_\_\_\_

Name of person/organization disclosing information\*: \_\_\_\_\_

**Name and date of birth of individual/client whose specific information is being disclosed:**

Child's Name\*: \_\_\_\_\_ Date of Birth\*: \_\_\_\_\_

**Expiration (select one)\*:**

This authorization's expiration date, event, or condition:

If no expiration date or condition is specified, this authorization/consent shall expire one year from the date this document was signed.

I understand that I may revoke this authorization/consent at any time by written notice to \_\_\_\_\_ except to the extent that records were released prior to the receipt of any written revocation. I understand that I may have a copy of this signed authorization/consent if I request it.

Parent/Guardian Signature\*: \_\_\_\_\_ Date Signed\*: \_\_\_\_\_

Parent/Guardian Name\*: \_\_\_\_\_ Relationship to Child\*: \_\_\_\_\_

If applicable, proof of parent/guardian authority included such as legal guardianship, court minutes, Notice to Provider from Department of Child Safety, or custody paperwork.