PINELLAS COUNTY SCHOOLS

AUTHORIZATION FOR STUDENT CONTACT / RELEASE OF INFORMATION

Parents / Guardians: This form gives permission for your child's information to be shared and / or for outside agencies to provide services or visit your child at school. It allows Pinellas County Schools to share your child's information with outside agencies, and for those agencies to share information with the district. You can also grant permission for these agencies to access your child at school for services or support.

Please review and complete the sections below to specify what information can be shared, who can access it. If you have any questions or need help, please contact us. Your consent helps us provide the best support for your child while ensuring their privacy.

Date _____

The undersigned hereby authorizes the School Board of Pinellas County, Florida, or its designated employee(s) or agent(s) identified on this form, to allow access to the student on campus and/or to release or obtain the specified information from the named agency(ies) or entity(ies) listed below. This authorization permits the exchange of educational, medical, or personal information between Pinellas County Schools and the agency(ies) listed, for the purposes outlined, in compliance with all applicable laws, including the Family Educational Rights and Privacy Act (FERPA) and other relevant state or federal regulations.

Pinellas County Schools, Florida

Attention: _____

Address

City | State | Zip

Telephone Number

Agency / Service Provider

Name of Agency and/or other Entity

Address

City | State | Zip

Telephone Number

Directions: (1) Mark all relevant boxes for the services and/or information being authorized. (2) The student information section must be fully completed, including all required fields: name (first and last), address, birthdate, school, and grade. (3) The parent / guardian authorization section must be fully completed including signature, date, and printed name.

Information Needed By: _____ / _____ / _____

Services and/or information will only be provided for selected box(es).

- ❑ Educational Records
- ❑ Exceptional Student Program Records
- ❑ Agency to see student on campus
- ❑ Biopsychosocial History
- ❑ Intellectual / Psychological / Psychiatric
- ❑ Medical / Neurological
- ❑ Service Summary
- ❑ Other: _____

STUDENT: First Name:_____ Last Name:_____ Birthdate:_____

Address:_____ City:_____ Zip:_____

School:_____ Grade:_____

This release remains valid for the duration of the specific service or purpose for which it was authorized, or until revoked in writing by the legal guardian or eligible student. A new release form should be completed for any additional or continuing services beyond the original scope of authorization. Information will be used only for the specific purposes approved by the custodial parent or legal guardian completing the form, in line with the selected item(s). Any shared information will be managed in accordance with federal and state laws, ensuring student privacy is maintained for all services and interactions authorized by this form.

Legal Parent / Guardian Signature [REQUIRED] | Date | Legal Parent / Guardian Printed Name [REQUIRED]

Student Signature | Date | Student Printed Name

The student must sign if 18 years of age or older.

For Agencies Handling Information Requests: *If you are unable to provide the requested records or if additional documentation is required to complete this request, please contact us promptly to resolve the issue. Your cooperation ensures timely support for the student's needs. Thank you.*