AUTHORIZATION FOR RELEASE OF INFORMATION

I, ______________________________, hereby authorize the exchange of records concerning between HARLEM SCHOOL DISTRICT 122, its agents and employees and Records Deposition Service, Inc. These disclosures are authorized pursuant to 20 U.S.C. Section 1232g, 105 ILCS 10/1 *et seq.*, and 740 ILCS 110/1 *et seq.*,* and are to be made for the purpose of discovery before trial. I understand that I have the right to inspect and copy the information to be disclosed, challenge its contents, and limit my consent to designated records or portions of the information contained in those records. I also understand that my refusal to consent to the exchange of all records and communications could result in a____. This consent expires one year from the date indicated below. However, I understand that I have the right to revoke this consent in writing at any time.

____ ____________

PARENT SIGNATURE DATE

____ ____________

STUDENT SIGNATURE (for mental health/ developmental disability records, if student is age 12 or older) DATE

____ ____________

WITNESS SIGNATURE (for mental health/ developmental disability records) DATE

* NOTE: Prior to the release of protected health information, health care providers may require the parent/guardian to execute an additional authorization form to comply with the Health Insurance Portability and Accountability Act ("HIPAA").

PLEASE SEND DOCUMENTS TO:

RECORDS DEPOSITION SERVICE, INC.

120 W. MADISON ST., SUITE 300

CHICAGO, IL 60602

P: 312-553-8900
F: 312-553-8901