

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:

\_\_\_\_\_  
Date of Permission    Signature of Parent/Guardian or  
Adult Student Over Age 18