Office of Special Education, Records Center
2205 Church Street, Conway, SC 29526
Phone: 843-488-6226 FAX: 843-488-7788

AUTHORIZATION for RELEASE of INFORMATION

I hereby authorize the release of information to: Horry County Schools

_____ (School Name)

_____ (School Address)

_____ (School Phone)

_____ (School FAX)

_____ _____

Child's Full Name (PLEASE PRINT) Date of Birth

Horry County Schools may exchange and use information from the following in making decisions:

□ Developmental Pediatrics □ Baby Net □ Therapy Consortium
□ Children's Rehabilitative Service □ Pee Dee Speech & Hearing □ Pawley's Pediatric Rehab
□ Waccamaw Mental Health □ McLeod/Loris Hospital/McLeod/Seacoast Medical
□ Other: _____

Covering the period(s) of treatment: From: _____ To: _____

Information to be released:

□ academic and attendance records □ medical records
□ anecdotal records □ placement & due process papers (student with a disability)
□ aptitude test scores □ psychological/educational evaluation report
□ audiological evaluation report □ social history report
□ class standing □ standardized achievement test scores
□ counseling records □ therapy record
□ extracurricular activities □ verification of birth date
□ individualized education program (IEP for student with a disability)
□ Other _____

Type of Access Requested: _____ Copies of the Record **OR** _____ Inspection of the Record

Purpose of disclosure: _____ Continuum of Care _____ Insurance _____ Legal _____ Educational

Other _____
(Please explain)

This authorization expires 12 months from the date signed below and only covers the dates specified above.
I understand that this authorization may be withdrawn at any time. I understand that the information disclosed under this authorization may be re-disclosed by the recipient of the information. The school district is released and discharged of any liability and the undersigned will hold the school district harmless for complying with this "Authorization for Release of Information". I understand that I have the right to refuse to sign this authorization and the school district may not condition treatment based upon my refusal to sign unless the authorization is necessary for related treatment or services provided solely for releasing information to a 3rd party.

A photocopy of the Authorization is to be considered as valid as the original. Fees/charges will comply with all laws and regulations applicable to release of information.

Signature of Parent/Guardian: _____ Date: _____

Parent Name (PLEASE PRINT): _____

Home Address: _____

City, State & Zip: _____

Best Contact Number: (Home): _____ OR (Cell) _____