DISTRICT OF COLUMBIA
PUBLIC SCHOOLS

DCPS Authorization for Release of Education Records

I am the parent of ____and I hereby give
(Student's Name and date of birth)

consent to the appropriate official at my child's school or the DCPS Office of Data and Strategy to release my child's education records to:

____
(Name of representative, agency, physician, or attorney)

____
(Address and phone number of representative, agency, physician, or attorney)

The purpose of the disclosure is:

____

____.
(Describe the specific purpose for the records disclosure)

By signing below, I authorize the release of the following records:

____

____.
(Describe specifically which records are to be released including any applicable date range)

By signing below, **1) I acknowledge and understand that I have the opportunity to review the records to be disclosed and the right to challenge the contents of such records**; 2) I am 18 years of age; and 3) I am signing this document on behalf of my child because he/she is not 18 years of age.

NOTE: This release is valid only for the purpose stated. The DCPS must obtain my written authorization before releasing any further information to any other requester. **This authorization will expire one year from the date of signature.**

______________________________ (Date)

____ (Parent/Guardian Signature)

____ (Parent/Guardian Current address)

____ (Parent/Guardian contact number)