Walsh Academy
6935 West Touhy Avenue, Niles, IL 60714

P: (847) 390-3020
F: (847) 294-1792

Release of Information

(2025 – 2026)

Student Name _____ **Birthdate** _____

I, as the parent/guardian of the above identified student, authorize Walsh Academy faculty to request, release and/or exchange the following indicated information regarding my student with the below identified persons/providers:

☐ **Individualized Educational Plan (IEP)**	☐ **IEP Domain Testing & Reports**	☐ **Therapeutic Summaries**
☐ **Grade Reports**	☐ **Progress Reports**	☐ **Attendance Reports**
☐ **Disciplinary Reports**	☐ **Discharge Summaries**	☐ **All School Student Records**
☐ **Mental Health Treatment**	☐ **Legal / Court Reports**	☐ **Probation Status / Compliance**
☐ **Data Reported by Home School District to ISBE IWAS/SIS system**	☐ _____	☐ _____

Pursuant to 20 U.S.C. § 1232g, 105 ILC 10/1 et seq., and 740 ILCS 110/1 et.seq., I authorize the disclosure of the above identified information for the following indicated purposes:

☐ Educational / Transitional Planning	☐ Continuity of Care	☐ Social Security Benefits Linkage
☐ Public / Private Services Linkage	☐ Legal / Probation Proceedings	☐ Legal / Probation Compliance
☐ _____	☐ _____	☐ _____

I understand I have the right to revoke this authorization in writing at any time. I understand that this authorization is limited only to the information listed above, which will only be released to/from the persons/providers listed below. 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 understand that my refusal to consent to the release of the information specified above will prevent disclosure of such materials to the persons/providers listed below, with the potential consequence of impeding the purposes stated above. This consent is valid until one (1) year after below date of parent/guardian signature.

Home School District	**Person / Provider**	**Person / Provider**
Contact Name	Contact Name	Contact Name
School District Name	Provider Agency	Provider Agency
Street Address	Street Address	Street Address
City, State, Zip Code	City, State, Zip Code	City, State, Zip Code
Phone # / Fax #	Phone # / Fax #	Phone # / Fax #

Student (Print Name) _____ Signature _____ Date _____

** Student signature required if 12 years or older and records contain mental health and/or developmental disability information.**

Parent / Guardian (Print Name) _____ **Signature** _____ **Date** _____