

PARENT PERMISSION TO OBTAIN AND RELEASE INFORMATION OUTSIDE AGENCIES

Date: _____

Student Name: _____
Last First MI

Address: _____
Street/PO Box City State Zip Code Home Telephone #

Tribal Information: _____
Tribal Affiliation Tribal Enrollment #

I, the undersigned, hereby request and authorize:

AND

**Ho-Chunk Nation Disabilities Program
Attn.: Cheryl Funmaker
P.O. Box 667
Black River Falls, WI 54615**

School District Name: _____
Office: _____
Street Address: _____
City, State, Zip: _____

To exchange requested information pertaining to the student named above which has been indicated below:

- Official Student academic/administrative records (identifying information, grade level completed, grades, class rank, attendance records, and group aptitude and achievement test results)
- Medical and/or related health records
- Psychological evaluations or social work reports
- Individualized education team evaluations and related reports
- Appropriate agency reports
- Individualized education program (IEP)
- Other (specify): _____

This permission is valid for one year from the date signed. A copy of this form is as effective as the original.

Parent / Guardian

Signature: _____ Date: _____

NOTE: Ho-Chunk Nation Department of Education reserves the right to information gathered during this period.

HCN Education Department
Phone: (715)284-4915 * Fax: (715) 284-1760 * Email: Education.Intake@Ho-Chunk.com