347-Exhibit 2

Authorization for Release of Information

Date: _____

Student's Name: _____

Date of Birth: _____

School: _____ Grade: _____

Williams Bay Public Schools
P.O. Box 1410
Williams Bay, WI 53191
Elementary Phone: 262-245-5571
MS./Sr. High Phone: 262-245-6224

Parent Name: _____ Authorizes Williams Bay School District

___ To release the specific information identified below ***to***:

___ To obtain the specific information identified below ***from***:

Name of individual or entity: _____

Address: _____

_____

___ Health Records
___ Medical Records
___ Chemical Use/Abuse Dependency Report
___ Psychological Reports
___ Psychiatric Report
___ Teacher/Counselor/Staff Observations
___ Special Education Records
___ Social Work Report
___ Other : _____
_____

For the purpose of: _____

_____

_____

I understand this authorization takes effect the day I sign it, and that it cannot exceed one year.

It expires either: ___ on : _____ *(or)* ___ one year from the date of my signature

I understand this authorization can be stopped any time by sending a written request to:

Williams Bay Public Schools
P.O. Box 1410
Williams Bay, WI 53191

I further understand:

- that I may refuse to sign this authorization and it will not affect my child's ability to receive educational services.
- that a copy of this release form is as valid as an original, and
- that I will receive a copy of this authorization

_____ _____

Parent/Guardian Signature Date