Ho-Chunk Nation Education Department
Disabilities Division

Release of Information consent within Education Department

Student Name_____D.O.B._____

Street Address _____

City/State/Zip Code: _____

Records Requested From _____

TYPE OF RECORDS REQUESTED:

_____Consent to communicate to Ho-Chunk Nation Disabilities Division regarding student academic, assessment, disciplinary, and special education records through the end of 20___School Year.

PURPOSE:

1) To assist student & parents in the development of the IEP.
2) To assist student & parents in advocacy.
3) To assist student & parents in Pre-K special education requests.
4) To assist student & parents in transitioning to Higher Education.

DISCLOSURE OF RECORDS WILL REMAIN WITHIN:

Ho-Chunk Nation Education Department

I understand that my records are protected under the CFR25, Part 43, 1-23 and cannot be disclosed without my written consent, other than the above mentioned. Any re-release of these records will result in immediate revocation. I also understand that I may revoke this consent at any time, except to the extent that the action has been taken in reliance on it and that in any event, this consent expires automatically within twelve (12) months from this date.

_____ _____

Student Signature **Date**

_____ _____

Parent Signature **Date**

Education Department Disabilities Division
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Black River Falls, WI 54615
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Fax: 715-284-1760
Education.Intake@Ho-Chunk.com