Suquamish Tribe

Education Department

18490 Suquamish Way NE, Suquamish, WA 98392
360-394-8576 Main / 360-394-7120 Fax

AUTHORIZATION OF RELEASE OF CONFIDENTIAL INFORMATION

Student's Name_____Birth date _____

Parent/Guardians Name _____

Address_____

Phone _____Email _____

To assist and promote my child's academic success, I authorize and request

_____ _____ _____

Name of School School District Grade

and its personnel, staff, officers, agents, teachers, authorized representatives, to discuss my child's academic needs and to release confidential records to the Suquamish Tribe's Education Department. This authorization is effective for the duration of my student's enrollment in the above listed school or school district and shall only expire upon my request. I understand that I may revoke this authorization at any time and that I have the right to inspect the information disclosed upon reasonable notification to the Tribe's Education Department.

By checking the box below, I authorize the following confidential records to be disclosed to the Suquamish Tribe Education Department:

- ☐ School Records: Grades /Attendance / Discipline/ Testing / Credit Evaluations
- ☐ Special Education Records: IEP / 504
- ☐ Tribal Enrollment Records
- ☐ Other (Please Specify) _____

I understand that the confidentiality of these records will be protected in compliance with tribal, state and/or federal law. No information will be released without my written consent unless disclosure is permitted by a court order.

I understand that a copy of this release will be kept on file with the Native American Program Office of the North Kitsap School District or at a specific school within the District and original form at the Suquamish Tribe Education Department.

_____ _____ _____

Parent/Legal Guardian (Print Name) Parent/Legal Guardian (Signature) Date

Approved form as of 09/18/2020 by Legal