



Osage Nation Education Department

102 Buffalo Ave.
Hominy, OK 74035
(918) 287-5300

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF EDUCATION RECORDS

The Family Educational Rights and Privacy Act (FERPA) is a federal law that protects the privacy of student education records created or maintained by a school that receives federal funds. Completion of this document authorizes the disclosure and use of education records as described below. Completion also authorizes you to discuss this information with representatives of the organization named below entitled to receive said information.

Student Information	
Student Name:	Date of Birth:
Social Security No.:	Grade:
Name of School:	
Parent/Legal Guardian:	Relationship to Student:

Use & Disclosure Information

I, the undersigned, do hereby authorize _____ to disclose and deliver the complete education records maintained under the above student's name including but not limited to the following:

- Grades and transcripts
- Psychological & Educational testing
- Verbal Information
- School health records
- Special education records
- Discipline

Please list any records you do not wish to be disclosed:

The education records described above shall be delivered to the Osage Nation c/o Osage Nation Education Department located at 627 Grandview Avenue, Pawhuska, OK 74056. For questions please call Mary Wildcat, Director at (918) 287-5300.

Purpose

This information is to be disclosed and used for the purpose of:

- Special Education
- Evaluation & Planning
- Provision of Special Education Services
- Other

Authorization for Redislosure

Under federal law, the Osage Nation may not disclose the information identified above to any other party without your prior consent. If you wish to authorize the Osage Nation to disclose the information identified above please mark the box below:

I authorize the Osage Nation to disclose the education information described above and I understand that if the information is disclosed it may not be protected by federal privileges, privacy laws or regulations.

Approval

My authorization for the use, disclosure and/or redisclosure of the information identified above is voluntary. I understand that the information to be disclosed or redisclosed may include individually identifiable health information. I understand that, upon my request, I am entitled to a signed copy of this authorization form and the records to be disclosed. Unless sooner terminated in writing, this release shall remain effective for 1 year from the date signed below. A copy of this release shall be sufficient to authorize release of information identified above as the original signed by me.

Student's Parent/Legal Guardian

Date

Relationship to Student