



**ST. COLETTA'S**  
OF ILLINOIS  
KENNEDY SCHOOL

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**AUTHORIZATION TO RELEASE/REQUEST EDUCATIONAL OR  
MEDICAL RECORDS AND EXCHANGE OF CONFIDENTIAL INFORMATION FY23**

I, the undersigned parent/guardian of \_\_\_\_\_ born \_\_\_\_\_  
Do hereby authorize

Lt. Joseph P. Kennedy Jr. School  
18350 Crossing Drive  
Tinley Park, IL 60487  
Fax 708-429-3467

Release/request/exchange of the records for above referenced student to/from:

Name of School/Agency \_\_\_\_\_

Name of Contact Person \_\_\_\_\_

School/Agency Address: \_\_\_\_\_  
\_\_\_\_\_

School/Agency Phone Number: \_\_\_\_\_

I understand the records to be released/requested may include psychological, social, medical, and educational records, including the individualized education plan (IEP).

Parent/Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_

Student (if own guardian) \_\_\_\_\_ Date \_\_\_\_\_