

AUTHORIZATION FOR RELEASE OF INFORMATION

STUDENT'S NAME: _____

DATE OF BIRTH: _____

I, the undersigned, do hereby authorize _____
(person or agency) to disclose/exchange the following records and information regarding the
above student with:

NAME: _____

ADDRESS: _____

PHONE #: _____

FAX #: _____

Description of records/information to be disclosed/exchanged:

Purpose for disclosure/exchange of records/information:

THIS AUTHORIZATION EXPIRES ON (INSERT DATE OR EVENT): _____

If no expiration date or event is specified, this authorization will expire one year from the date it was signed.

I understand that I have the right to inspect and copy the information to be disclosed, challenge its contents, and limit my consent to designated records or portions of the information contained in those records. I also understand that my refusal to consent to the exchange of records and communications could result in incomplete and/or inappropriate educational planning for _____.

Parent/Guardian Signature

Date

Student Signature (for mental health/developmental
Disability records, if student is age 12 or older)

Date

Witness Signature (for mental health/
Developmental disability records)

Date

***NOTE:** Prior to the release of protected health information, health care providers may require the parent/guardian to execute an additional authorization form to comply with the Health Insurance Portability and Accountability Act (AHIPAA@).