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AUTHORIZATION FOR RELEASE/EXCHANGE OF RECORDS

Parent/Guardian Name: ____ Date: _________________

Student Name: ____ Birthdate: ______________

School: ______________________________________

I hereby authorize the release of records and confidential information:

From: _________________________________ **To:** ____
Name of agency/person / Name of agency/person

__________________________________ ____
Street Address / Street Address

__________________________________ ____
City, State, Zip / City, State, Zip

☐ Authorization is for mutual sharing of information and release of records by both parties to the other party.

Describe the records to be disclosed:
☐ Medical records/authorization is valid for 90 days.
☐ Mental health records/authorization is valid for 90 days.
☐ Special education records/authorization is valid for one year.
☐ Other ____

The reason for requesting release of record(s) is:
☐ determining special education eligibility,
☐ planning student's educational program,
☐ other ____

Please note that if the request is for health or medical information, the medical information received by the district is protected under FERPA privacy standards by a school district and not the Health Insurance Portability and Accountability Act (HIPAA).

This authorization is valid from ____/____/____ to ____/____/____.
Note: For release of medical records, the authorization can be no longer than 90 days after this authorization is signed.

I understand that my consent for the release of records is voluntary and I can withdraw my consent at anytime in writing. Should I withdraw my consent, it does not apply to information that has already been provided under the prior consent for release.

____ ___________________
Parent/Guardian or Student Signature Date

 Copies: District/Agency/Practitioner, OSDSS Office, Parent/Guardian/Adult Student