Student Name: **Student Id:**

AUTHORIZATION FOR EXCHANGE OF CONFIDENTIAL EDUCATION & HEALTH INFORMATION

Student Name: **Date of Birth:**

I hereby give permission to release records and share confidential information listed between

AND School/Agency _____

Address

This requested information will be used for the purposes of Educational evaluation / programming and Health assessment and planning for health care services and treatment in school.

The requested information consists of:

☐ All School Records

☐ All Special Education Records

☐ Specific Records

- ☐ Psychiatric Evaluations
- ☐ Psychological Evaluations
- ☐ Attendance Reports
- ☐ Medical physical & immunizations
- ☐ Medical Information/Records
- ☐ Social History
- ☐ Speech/Language Evaluations
- ☐ Physical Therapy Evaluations
- ☐ Occupational Therapy evaluations
- ☐ Attendance Reports
- ☐ Other (specify)

Consent requested by _____

Name Title Date

Authorization

This authorization is in effect through (not to exceed one year). I understand that I may withdraw this authorization at any time by submitting a written notice. I recognize that health records, once received by the school district, may not be protected by the HIPPA Privacy Act, but will become education records protected by the Family Educational Rights and Privacy Act.

_____

Parent/Guardian/Surrogate Date

_____

Student (if 18 years or older) Date

Copies: Parent or Student, Agency & Requesting School