PARENT/GUARDIAN/STUDENT
CONSENT FOR RECORDS RELEASE

Student Information

Last Name	First Name	Middle
Date of Birth / /	Phone Number	
Address		
City	State	Zip Code

Provider Information

Last Name	First Name	Phone # ( )
Email address	Fax # ( )	
Address	City	
State	Zip Code	Agency

Information Release to

Last Name	First Name	Phone # ( )
Email address	Fax # ( )	
Address		
City	State	Zip Code

We are requesting the following information/records for the above-named student:

☐ All personally identifiable data on file.

☐ Consultation/Records regarding all clinical and diagnostic impressions that are pertinent to the academic and social-emotional well-being of the student (treatment plans, etc).

☐ The following records only (please specify): ____________________________________
____

Reason for request: (please check)

☐ To aid in making present and future educational decisions

☐ Other (please specify): ____
____

Form of Disclosure:

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

With the understanding that the district cannot assume responsibility for the confidentiality of educational information disclosed, I authorize you to release education information regarding the above-named student in the manner indicated.

I understand that this request will expire one year from the date of my signature below.

By signing below, I affirm that I am the student and/or the student's personal representative and have the authority to authorize who may access or receive this student's health information.

____	___________________________________
Printed Name of Student (or Personal Representative)	Relationship to Student
____	___________________________________
Signature of Patient (or Personal Representative)	Date

8/16/18