Woodridge Local School District

SECTION 504 RELEASE OF INFORMATION AND RECORDS

In order to ensure your child is provided with equal access (both physical and academic) to services, programs and activities offered by our school, a mutual exchange of information and records is required for your child.

Name of Student: _____ DOB: _____

School: _____ Grade: _____

The requested exchange is between the _____ School District and the following:

_____

_____
(hospital, clinic, physician, institution, association, or school)

Address: _____

Name of Contact Person: _____ Phone: _____

Records that may be exchanged include the following: (check all that apply)

_____ Release all information
_____ Release the checked information:

_____ General identifying data (name, address, birth date, grade level completed, grades, class standing, attendance record)
_____ Standardized achievement and aptitude test scores
_____ Personality and interest scores
_____ Teacher ratings
_____ Record of extra-curricular activities
_____ Individualized education programs
_____ Psychological reports
_____ Medical reports
_____ Psychiatric report
_____ Other: _____

Consent of Parent/Guardian for Release of Information

I authorize _____ School District and the above named individual/organization/agency to exchange information and records as indicated. Except as limited above, this authorization encompasses all information pertaining to the minor, including protected health information (PHI) as defined in the Health Insurance Portability and Accountability Act (HIPAA) and its implementing regulations, and education records as defined in the Family Educational Rights and Privacy Act (FERPA) and Ohio Revised Code Section 3319.321.

We expressly waive all provisions of law (including, but not limited to, the privacy provisions of HIPAA, FERPA, and R.C. 3319.321), forbidding any physician or other person who has or may hereafter treat, attend, or examine the minor, or any educational agency, from disclosing any knowledge or information, including PHI, which they may have thereby acquired.

Pursuant to HIPAA, the following are specified as part of this authorization:

a. The purpose of disclosure is for assisting the School District in offering the student a free appropriate public education pursuant to Section 504 of the Rehabilitation Act of 1973.

b. This authorization expires one (1) year after the date it is signed.

c. The parents signing this permission form understand that they may revoke this authorization at any time by providing written notification to the District Compliance Officer, the building principal/Building Compliance Officer, or the individual/organization/agency listed above, except to the extent that this authorization has already been relied upon.

d. The parents signing this form have been informed that the individual/organization/agency listed above may not condition treatment, payment, enrollment, or eligibility for benefits on whether the parents sign this authorization.

e. The parents signing this form have been informed of the potential for information disclosed pursuant to this authorization to be subject to redisclosure by the recipient and to be no longer protected by HIPAA. The parents signing this form are also aware that any information disclosed to the School District is subject to other state and federal privacy laws.

_____	_____	_____
Parent's Signature	Relationship to Student	Date Signed

Address: _____ Phone: _____

Please send released information/records to:
_____ (Principal/Designee)
_____ (School)
_____ (Address – line 1)
_____ (Address – line 2)

Copies to: [ ] Parent/Guardian [ ] Cumulative Folder

1/16/07
10/19/10