

INDEPENDENT SCHOOL DISTRICT 196
Rosemount-Apple Valley-Eagan Public Schools
Educating our students to reach their full potential

Series Number 505.2.3P Adopted January 1978 Revised September 2014

Title Prior Consent to Release Private Data To or From an Outside Agency/Person

Parent/guardian: This form allows information about your child to be exchanged. Please sign and return it to the school.

Student's full name _____

Date of birth ____ - ____ - ____

School _____ Grade _____

Parent/guardian name _____

Parent/guardian address _____

I authorize _____
school district name and/or number and person responsible

address _____

city _____ state _____ zip _____

(check as needed) _____ to release information to:
_____ to obtain information from:

name _____ title _____

organization _____

address _____

city _____ state _____ zip _____

The purpose for the request _____

School records may be examined by parent/guardian, or student age 18 or older. A copy of this consent form will be provided upon request. Please release the following:

- | | |
|--|--|
| <input type="checkbox"/> Test results and other non-directory information in the cumulative folder | <input type="checkbox"/> Social work reports |
| <input type="checkbox"/> Chemical abuse/dependency report(s) | <input type="checkbox"/> Psychiatric reports |
| <input type="checkbox"/> Health record | <input type="checkbox"/> Medical report (including related services) |
| <input type="checkbox"/> Teacher, counselor, staff observations | <input type="checkbox"/> Psychological reports |
| <input type="checkbox"/> Child study/special education records (including related services) | <input type="checkbox"/> Other (specify) _____ |
| | <input type="checkbox"/> Other (specify) _____ |

I understand this authorization takes effect the day I sign it. It expires on _____
(month, day, year)

or no more than one year from the date of my signature. I also understand that I may change this authorization at any time by notifying the school principal or staff member identified above. I may refuse to sign this authorization and it will not affect my child's ability to receive educational services. I understand that I am entitled to a copy of this authorization. I understand that the laws that protect the information disclosed may allow or require the re-disclosure of the information, but only as permitted by law.

HIPAA STATEMENT: If this consent form provides for the release of "protected health information" (PHI) as defined by the Health Insurance Portability and Accountability Act (HIPAA), I understand that redisclosure of PHI by the recipient may no longer be protected by HIPAA. Treatment, payment, enrollment or eligibility of benefits from a health plan or health care provider may not be conditioned on obtaining this consent.

Signature of parent/guardian/student age 18 or older *Date*

Photocopy valid as original.

Copies: Child Study file (if one exists) Cumulative folder Other _____