Telephone: 906-863-5665

MENOMINEE COUNTY ISD
Intermediate School District

Fax: 906-863-7776

1201- 41st Avenue
Menominee MI 49858
Http://mc-isd.org

CONSENT FOR ACCESS/RELEASE OF INFORMATION

Student Name _____**Date of Birth** _____

Address_____

I hereby Authorize the release of information from:

(Doctor/Clinic/Hospital/Facility)_____

Address_____

Phone _____ **Fax** _____

To disclose information to:

Menominee County ISD
1201 41st Ave, Menominee, MI 49858
Phone : 906.863.5665, ext 1010 Fax: 906.863.7776

Information to be disclosed:

_____ Medical _____ Mental Health from date _____ to date _____

Information is requested for: _____ Educational Planning/Placement _____ Other

This authorization is voluntary. I can choose to revoke this consent at a later date, however the revocation must be in writing. If this consent is revoked, I understand that information may have been released prior to the cancellation, and that action would not be considered a breach of confidentiality. I also acknowledge that once my health/education information is used or disclosed pursuant to this authorization, it may no longer be protected by federal or state law, unless protected by Federal Regulations 42CFR Part 2 and the Public Act 258 in which case it cannot be re-disclosed by the Receiving Party without my written authorization. I understand the information may be released electronically. This agreement will expire one year from the date of signature, unless revoked in writing by the parent/guardian sooner.

Initial: _____ This is a two-way release to exchange information between parties identified above.

_____ _____
Signature of Parent/Legal Guardian (if student is a minor) Date

_____
Printed name of Parent/Legal Guardian (if student is a minor)

_____ _____
Witness Signature Date