CONSENT FOR ACCESS/RELEASE OF INFORMATION

Student Name _____ Date of Birth _____

Address _____

I hereby Authorize _____

Address_____

Phone _____ Fax _____

To disclose information to _____

Address_____

Phone _____ Fax _____

Information to be disclosed:

_____ Medical from date ____/____/____ to date ____/____/____

_____ 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 be subject to re-disclosure or release by the receiving party and 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, or as indicated (specify number of days or months) _____ unless cancelled by the parent/guardian.

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

_____ _____
Signature of Parent/Legal Guardian Date

_____ _____
Complete mailing address of consenting party Phone Number
(if different than above)

_____ _____
Witness Signature Date