Authorization for Release of Information

Section I. [1]

Student's Name: _____ **Date:**_____

Date of Birth: _____/_____/_____ (mm/dd/yy) **ID:** _____ **Grade:**_____
School:_____

Section II [2]

Parent/Guardian Name: _____

  Authorizes: _____   _____
                     District Name / Number   Staff Person Responsible

                         _____   _____
                     School Responsible   Address

☐ to release the specific information identified below *to*:

☐ to obtain specific information identified below *from*:

Name of individual or entity, Title: _____ Organization: _____

Address: _____

☐ Health Records   Created between _____/_____/_____ (mm/dd/yy) and _____/_____/_____(mm/dd/yy)
☐ Medical Reports   Created between _____/_____/_____ (mm/dd/yy) and _____/_____/_____(mm/dd/yy)
☐ Chemical Abuse/   Created between _____/_____/_____ (mm/dd/yy) and _____/_____/_____ (mm/dd/yy)
      Dependency Report
☐ Psychological Reports   Created between _____/_____/_____ (mm/dd/yy) and _____/_____/_____ (mm/dd/yy)
☐ Psychiatric Report   Created between _____/_____/_____ (mm/dd/yy) and _____/_____/_____ (mm/dd/yy)
☐ Teacher, Counselor, Staff   Created between _____/_____/_____ (mm/dd/yy) and _____/_____/_____ (mm/dd/yy)
      Observations
☐ Special Education Records   Created between _____/_____/_____ (mm/dd/yy) and _____/_____/_____ (mm/dd/yy)
☐ Social Work Report   Created between _____/_____/_____ (mm/dd/yy) and _____/_____/_____ (mm/dd/yy)
☐ Others *(specify)*   Created between _____/_____/_____ (mm/dd/yy) and _____/_____/_____ (mm/dd/yy)

For the purpose of :

_____

_____

_____

Section III [3]
I understand this authorization:
- takes effect the day I sign it,
- cannot exceed one year, and expires either:
  - ☐ on ___/___/___ (mm/dd/yy), or
  - ☐ one year from the date of my signature,

- can be stopped any time by sending a written request to:
  _____
  _____
  _____
  _____

I further understand:
- I may refuse to sign this authorization and it will not affect my child's ability to receive educational services,
- the laws that protect the information identified on this release, in some situations, may allow or require this entity to re-disclose this information, but only as permitted by law Health Insurance Portability and Accountability Act [HIPAA], Family Educational Rights & Privacy Act [FERPA], Minnesota Government Data Practices Act [MGDPA or Chapter 13]),
- a copy of this release form is as valid as an original, and
- I will receive a copy of this authorization.

Signature: _____ **Date:**_____
                Parent, legal representative or student   (mm/dd/yy)
References to regulations [4]   MDE -06/14/06