CONSENT FOR RELEASE & EXCHANGE OF INFORMATION

Student's Name:_____ Grade:_____ Date of Birth: _____

Parent(s) Name:_____ Phone: _____

Address: _____

1. I authorize Lakeville Public Schools to obtain information from and to disclose information to the following individual or organization:

Name:_____ Phone:_____Fax: _____

Organization:_____

Address: _____ State: _____ Zip:_____

2. The type and amount of information to be used or disclosed is as follow: (include dates where appropriate).

- ☐ Health record/Medical Report
- ☐ Lab/X-ray reports
- ☐ Immunization record
- ☐ Psychological/psychiatric Report
- ☐ Official school records (attendance, grade level, grades, local test results)
- ☐ Special Education records (IEP, Evaluation reports, Progress Reporting)
- ☐ Teacher, Counselor, Staff Observations
- ☐ Social Work report
- ☐ Other (please specify):_____

3. This information may be disclosed to and used by the following district staff:

- ☐ School Nurse
- ☐ Occupational Therapist (OT)
- ☐ Physical Therapist (PT)
- ☐ Speech/Language Pathologist
- ☐ Psychologist
- ☐ Counselor
- ☐ School Social Worker
- ☐ Evaluation Team
- ☐ Other:_____

School: _____

Address: _____

For the purpose of:

- ☐ appropriate education programming
- ☐ development of routine and emergent school management
- ☐ assessment of impact of medical condition(s) on school programming

4. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the school my child attends. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____

5. If I fail to specify an expiration date, event or condition, this authorization will expire in **one year**. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure educational services. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the school district office.

_____ _____

Signature of parent, legal guardian or student (if over 18) Date

Please Note: This information has been disclosed to you from confidential records protected from disclosure by state and federal law. No further disclosure of this information should be done without specific, written and informed release of the individual to whom it pertains or as permitted by state law (ORC – 3701.243) and federal law 42 DFR, part II.