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 **May 2018**

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

____
phone number email fax number

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

____
name title

____
organization

____
address

____
city state zip

____
phone number email fax number

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:

- __ Test results and other non-directory information in the cumulative folder
- __ Chemical abuse/dependency report(s)
- __ Health record
- __ Teacher, counselor, staff observations
- __ Child study/special education records (including related services)
- __ Social work reports
- __ Psychiatric reports
- __ Medical report (including related services)
- __ Psychological reports
- __ Other (specify) ______________________________
- __ 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______________________