Rochester Public Schools	ROCHESTER PUBLIC SCHOOLS STUDENT SUPPORT SERVICES 615 SW 7TH STREET SW ROCHESTER, MN 55902	CONSENT TO RELEASE PRIVATE DATA

Student Name: _____ ID: _____ Date: _____

School: _____ Grade: _____ D.O.B. _____

This form allows information about your child to be exchanged. Please sign and return it.

Parent/Guardian Name: _____

Parent/Guardian Address: _____

I hereby authorize Independent School District 535, the Rochester Public Schools, and its staff as follows:

☐ to release information to:

☐ to obtain information from:

(Check either or both boxes, as needed)

Name, Title Organization

Street Address City State Zip Code

School records may be examined by guardian(s), or student if age 18 or older. The information to be released:

- ☐ All School records and educational data
- ☐ All health records and related data
- ☐ Psychological reports and related data
- ☐ Special education and all related records and data
- ☐ Other
- ☐ Billing records
- ☐ Chemical Abuse/Dependency data
- ☐ Medical Report (including related service)
- ☐ Psychiatric Report
- ☐ Social Work report

The purpose for this request: _____

I understand that this authorization takes effect the day I sign it. It expires on _____ or no more than one year from the date of my signature, whichever is earlier.

I also understand that I may revoke this authorization at any time by providing a signed, written notice of revocation to the Director of Student Services for the Rochester Public Schools. A photocopy or facsimile of this Authorization has the same legal effect as the original.

In the case of protected health or medical information, I hereby authorize the healthcare provider to discuss, disclose, and otherwise release any and all medical records, medical data, and heath data identified above to the Rochester Public Schools and its staff and representatives pursuant to the Health Insurance Portability and Accountability Act ("HIPAA") privacy regulations, 45 C.F.R. § 164.508. I understand that the healthcare provider may not condition treatment or payment on whether I execute this authorization. Health or medical information that is disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by the privacy regulations promulgated pursuant to HIPAA. Records that are received by the School District may be protected from re-disclosure under the Family Education Rights Privacy Act and the Minnesota Government Data Practices Act.

_____ _____

Parent Signature (Student if age 18 or older)

This form is available in several languages, Braille, or other formats. Contact the IEP Manager for an alternate format.

RRM: 90610