Glenview School District 34
1401 Greenwood Road
Glenview, Illinois, 60026-1511
www.glenview34.org

Authorization for Use and Disclosure of Protected Education Records and Health Information

Patient/Student Name: _____ **Date of Birth:** ____/____/_____

I hereby authorize: _____

_____Phone:_____

{Name, address and phone number of individual authorized to disclose records}

to disclose protected health information and/or educational records to: _____

_____Phone:_____

{Name, address and phone number of individual authorized to disclose records}

☐ Check if authorization is given for the parties listed above to mutually exchange the information.

☐ All Permanent Records
(including but not limited to basic identifying information, academic transcripts, attendance records, health records and scores received on all State assesments

☐ All Temporary Records
(including but not limited to scores on state assesments, discipline and health records, accident reports, test results, report cards, progress monitoring information, special education records, Section 504 records)

If not all records, please select all that apply from the choices bellow:

Education information:

___Grades/report cards/transcripts
___Psychological evaluations
___Speech and language evaluations/reports
___Educational testing (local and state)
___IEP's/504 plans/eligibility documents
___Health histories
___Occupational therapy evaluation/reports
___Physical therapy evaluation/reports
___Social assessments/histories
___Neuropsychological evaluations
___Assistive technology information
___Behavioral/discipline information

___Only covering the period of time
from ___/___ /___ to ___/___ /___

Medical information:

___Medical history
___Treatment plans
___Immunization Records
___Nursing Assesment
___School physical forms
___TB or other lab results
___Medication records
___HIV information
___Lead screening
___Dental

___Only covering the period of time
from ___/___ /___ to ___/___ /___

Mental health information:

___Treatment plans
___Psychiatric evaluations
___Psychological Evaluations
___Neuropsychological Evaluations
___Clinical assessments
___Treatment notes
___Clinical notes
___Medication records
___Discharge summaries
___Social assessment/history

___Only covering the period of time
from ___/___ /___ to ___/___ /___

Substance abuse information:
___Substance abuse history ___Discharge/continuing care plan ___Treatment, attendance placement and progress

This authorization is valid for one calendar year and will expire on _____. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I understand that my revocation of this authorization will not be effective for actions taken by the school district or health care provider in reliance upon my authorization and prior to notice of my revocation. I understand that failing to authorize disclosure of records may adversely impact the educational programming and/or medical treatment for my child.
I recognize that health records, once received by the school district, may not be protected by the HIPAA Privacy Rule, but will become education records protected by the Family Educational Rights and Privacy Act. I also understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain health care. I also understand that I have the right to inspect and copy educational records and to challenge their content.

_____ _____ ___/___/____
Parent Name (please type) Parent Signature Date

_____ ___/___/____
Student Signature (If student is over 12 years of age and the authorization is for the release of mental health records) Date

_____ _____ ___/___/____
Witness Name (please type) and Signature (If student is over 12 years of age and the authorization is for the release of mental health records) Date