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 assessments	☐ **All Temporary Records** (including but not limited to scores on state assessments, 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 below:

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 ___/___ /___	**Substance abuse information:** Medical information: ___Medical history ___Treatment plans ___Immunization Records ___Nursing Assessment ___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) Signature Date
(If student is over 12 years of age and the authorization is for the release of mental health records) ___ ___ /___ /___