MT VERNON COMMUNITY SCHOOL COOPERATION
AUTHORIZATION FOR RELEASE/EXCHANGE OF

Student Name:_____ DOB:_____

Parent or Legal Guardian Name:_____ Phone:_____

Address:_____City/State/Zip:_____

School:_____Grade:_____Teacher:_____

Medical Condition (s):_____

Authorization is hereby granted to Mt. Vernon Community School Corporation to (check all that apply):

☐ obtain information from: ☐ release information to: ☐ verbal communication with:

1._____ _____
Name of Physician, Agency, Individual, etc. Phone Fax

2._____ _____
Name of Physician, Agency, Individual, etc. Phone Fax

3._____ _____
Name of Physician, Agency, Individual, etc. Phone Fax

4._____ _____
Name of Physician, Agency, Individual, etc. Phone Fax

Information to be released (check all that apply):

☐ Individual Education Program (IEP)
☐ Initial Assessment
☐ Health and Medical Records/Information
☐ Permanent School Records
☐ Physical Therapy/Occupational Therapy
☐ Psychiatric/Psychological Records
☐ Vision/Audiology Records
☐ Speech/Language Therapy Reports

For office use only

Specific date ranges being requested:

_____ _____
Start Date End Date

For the Purpose of (check all that apply):

☐ Educational evaluation and program planning
☐ Medical/mental health evaluation and treatment for health care services and treatment in the school setting
☐ Initial Evaluation or Reevaluation by Physical Therapy or Occupational Therapy
☐ Consent to exchange information with physician and other therapists providing services

- This authorization is valid for twelve (12) months from the date of signing. At any time, I may revoke this release in writing. If I want it to expire on a different date, then that date is:_____. Revocation does not affect release of medical records made prior to the revocation. I understand that I have a right to receive a copy of this form after signing.
- I recognize that these records, once received by the school district, may not be protected by the Health Insurance Portability and Accountability Act (HIPAA), but will become education records protected by the Family Educational Rights and Privacy Act (FERPA).
- Signing this release is voluntary. Refusing to sign it will not affect the school or district's commitment to provide a quality education for the student. However, the requested records may be required in order for the school to implement an appropriate plan of education, learning accommodations/modifications, and or health care.
- I understand for the purpose of providing the most appropriate instruction and assistance in school, I am giving my permission for mutual exchange of psyco-educational evaluations or medical evaluations.
- Parents of a student with a disability have protection under the procedural safeguards described in the law: 511 IAC-7-37-1. If I have not previously received a copy of written notice of procedural safeguards and a list of resources for help in understanding my rights, I understand these can be obtained from my child's teacher or the Special Education office at 1806 W State Rd 234 Fortville, IN 46040.
- **By my signature below, I indicate that I am the parent or legal guardian of above named child. I authorize the release and use of the information in accordance with the rights, restrictions and understandings above to ensure health, safety and continuity of care for my child.**

_____ _____
Parent or Legal Guardian's signature **Date** **Copy to Parent_____(Initial)**

Revised Sept. 2019