Brownsburg Community School Corporation
310 Stadium Drive
Brownsburg, IN 46112
(317) 852-5726
FAX (317) 858-4105

CONSENT FOR MUTUAL EXCHANGE /RELEASE OF INFORMATION

For the purpose of providing appropriate instruction and assistance in school, I do hereby request and give permission for a mutual exchange/release of psychoeducational and/or medical information concerning:

Student's Name _____ Birth Date _____

Student's Address _____ School Where Enrolled_____

between the Brownsburg Community School Corporation and the following:

_____
(Hospital, Clinic, Physician, Institution, Association or School)

_____
(Address of Above - Including City, State and Zip)

_____ _____
(Name of Contact Person) (Phone)

Purpose:

☐ to enable the Case Conference Committee to develop, review, revise the Individualized Education Plan (IEP)
☐ to determine eligibility for special education
☐ to complete educational evaluation process
☐ other -specify _____
☐ to permit continuity of educational programming
☐ to refer family to other agencies - specify agency: _____
☐ to communicate with other agencies involved with the student - specify agency_____

Specific information To Be Disclosed:

_____ Academic Achievement/Transcripts
_____ Psychoeducational Evaluations
_____ Behavior Reports
_____ IEP/ITP
_____ Attendance
_____ Disciplinary Records
_____ Other - specify _____

To Be Obtained:

_____ Medical Information From:
_____ Optometrist or Ophthalmolgist
_____ Otologist or Otolaryngologist
_____ Audiologist
_____ Neurologist (diagnostic statement)
_____ Physician (diagnostic statement / order)
_____ Mental Health: Treatment Plan/Discharge Summary
_____ Other - specify _____

I may revoke this consent at any time by submitting my revocation in writing to the person listed below. I understand that my revocation is not retroactive and that there may have been action taken in reliance upon my original consent.

_____ _____
(Signature of Parent/Legal Guardian) (Address)

_____ _____
(Date Signed) (Phone)

Please return completed form to: _____
(Name)

_____
(Address)

_____
(City, State, Zip Code)

Redisclosure of information is prohibited unless additional written consent is obtained. Federal rules restrict any use of the information to criminally prosecute any alcohol or drug abuse patient. Consent will expire one (1) year from date signed unless noted otherwise.