ST. CLAIR COUNTY SCHOOLS
EVERY STUDENT PREPARED

BI-LATERAL HIPAA/FERPA CONSENT TO RELEASE AND RECEIVE INFORMATION

DATE: _____

Parent/Guardian Name: _____

Street Address: _____

City, State, Zip: _____

I/We _____ authorize St. Clair County Schools and
(Parent/Guardian)

_____ to
(List Agencies/Providers)

release and/or exchange information/records regarding my/our child, _____.
(Student's Name-First Middle Last)

Information/records includes, without limitation, personally identifiable information under HIPAA or FERPA; official student academic/administrative records (identifying grade level completed, grades, class rank, attendance records and aptitude and achievement test results); medical, psychiatric, psychological or other mental health records (excluding counseling notes); psychological evaluations or social work reports; IEPs, 504, ELL or RtI evaluations and related reports; all **Special Education** records and **Gifted** records, including, without limitation, student referral form, consent for evaluation, parental rights, vision and hearing screening, educational tests, IEPs and 504 Plans; appropriate agency reports; extracurricular activity participation; or other (as specified)_____.

AUTHORIZATION

This authorization is valid for one calendar year. It will expire on _____ [insert date]. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent and that the written revocation must be given to the agency/organization I authorized to release information. I also understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain health care and/or educational services.

_____
Parent/Guardian Signature Date

_____
Student Signature* Date
*If a student is eighteen (18) years old or older.

PLEASE SUBMIT RECORDS REQUESTED BY SCHOOL SYSTEM TO:

Requested by _____

School Name _____ Phone Number _____

Mailing Address_____

City/State/Zip_____