



Parent(s), this form allows information about your child to be exchanged. Please sign and return it to the school.

Learner's Full Name: _____ Grade _____

ID: Birthdate: Today's Date: ___/___/___ (M/D/Y)

Parent Name: _____ Parent Address: _____

I authorize _____ for Special School District No.1
at: _____ (Person responsible/Position)

_____ Minneapolis, MN _____

Address

Zipcode

to release written and verbal information to: _____
 to obtain written and verbal information from: _____
(Check either or both boxes as needed)

Name, Title _____

Organization _____

Address _____ City _____ State _____ Zip code _____

The information to be released:

- Social Work Report Psychiatric Report Psychological Report
- Medical Reports [immunizations, audiological and vision testing, recent physical exam, allergies, admission and discharge summaries, acute and chronic health problems]
- Chemical Abuse/Dependency Report (Student consent or separate court order needed)
- Others (specify) _____
- Others (specify) _____

The purpose for the request is:

- To determine health needs of your child that may require attention during school.
- To provide school personnel with a better understanding of your child's health needs.
- To facilitate evaluation of your child's individual educational program.

- 1) I understand that this consent takes effect the day that I sign it. It expires on _____ (M/D/Y) or no more than one year from the date of my signature.
- 2) I may revoke or change this consent at any time by sending a written notice of the revocation or change to the releasing school.
- 3) My or my child's eligibility for services may not be conditioned on the signing of this authorization.
- 4) Once the requested information is released from the HIPAA-covered entity, the information may no longer be protected by HIPAA, though information considered educational records under FERPA will be protected accordingly.

Month/Day/Year: _____

Parent/Guardian Signature (or Learner, if of legal age or to release chemical abuse/dependency treatment report)

- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by MPS and may no longer be protected by federal law.
- A photocopy of this completed form is valid as original.
- MPS is not authorized or funded to pay for this information.