Consent for Exchange of Information and Release of Records

Magoffin County Schools
25 School Drive
Salyersville, KY 41465
(606) 349-6117

I, _____________________________________, give my consent for the following persons/agencies to release/exchange information and confidential records concerning:

____________________________________ __________________ ___________________
Name of Student/Person | Date of Birth | Social Security Number

____
Relationship to Person

Address

Releasing Persons/Agencies:

Name ____________________________________
Address __________________________________
____

Name ____________________________________
Address __________________________________
____

Information Requested:

_____ Medical Records
_____ Psychiatric/Psychological Evaluation Results
_____ Inpatient Records/Discharge Summary
_____ Special Education Records
_____ Student Cumulative Records
_____ Developmental/Psychosocial History
_____ Diagnosis (Admission/Discharge)
_____ Number of Kept/Unkept Appointments
_____ Other ______________________________

_____ Lab Results/Drug Screens
_____ Department of Social Services Records
_____ Statement of Legal Status/Custody
_____ Treatment Plan/Medications
_____ Social Security Administration Records
_____ Physical Exam
_____ Substance Abuse Treatment Records
_____ Behavioral Charts/Schedule
_____ Other ____________________________

The above requested information is (released) for the purpose of:

_____ Educational Planning
_____ Treatment of Client
_____ Collaboration with Medical Staff
_____ Supplement Referral Information
_____ Collaboration with Mental Health Staff
_____ Completion of Developmental/Psychosocial
_____ Section 504 Referral/Review
_____ Other ____________________________

_____ Re-Entry into School District
_____ IEP Development

I understand that the release of the above records or the exchange of confidential information/records are protected under State and Federal Confidentiality Regulations and the Family Educational Rights and Privacy Act of 1974 and therefore cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time, except to the extent that actions (release/exchange) have already been taken. **Attention persons/agencies receiving records:** The information being disclosed to you is protected by Federal Conventionality Rules (42 CFR Part 2). This Federal rule prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to who it pertains or parent/guardian of that person.

____ ___________________

Signature of Parent/Guardian Date Signed

____

Date Consent Expires (Not to exceed one year)

_________________________________ _____________

Signature of Person/Client Date Signed

_________________________________ _______________

Signature of Witness Date Signed

(If Applicable)

Please send the above requested information to:

____

____

____

Fax:______________________

Note: A photocopy of this consent can be used in lieu of an original.