ISD 728 INDEPENDENT SCHOOL DISTRICT 728
ELK RIVER | OTSEGO | ROGERS | ZIMMERMAN

AUTHORIZATION TO RELEASE/OBTAIN CONFIDENTIAL AND PRIVATE DATA

Student Name:_____ School Name: _____

Date of Birth:_____ Grade:_____ Student ID:_____
Student Home Address: _____ City:_____ State:_____ ZIP:_____

Parent/Guardian Name (if student is under 18 years old): _____ _____

Authorization to Release Educational Data. I am the parent or legal guardian of the child named above. I understand that the term "educational data" means all recorded information that relates to the child who is named above and is maintained by Independent School District No. 728, Elk River Area Schools ("District"). By way of example, but without limitation, educational data may include grades; transcripts; attendance records; state-wide, district-wide, and classroom test results; class rank and GPA; disciplinary data; special education records; staff observations, and information maintained by the school health office.

To assist in the coordination of services, I authorize the District and its employees and representatives to release private educational data on my child to the following entity or organization:

Name of individual, entity, or provider: _____
Organization: _____
Address: _____

This release applies to all educational data unless I have noted an exception here: _____

Authorization to Release/Obtain Protected Health Information. Pursuant to the Health Insurance Portability and Accountability Act ("HIPAA") Privacy Regulations, which are found at 45 CFR § 164.508, and to further assist in the coordination of services, I authorize the following individual, organization, or health care provider to release the following records to the District, including any of its employees or representatives:

Name of individual, entity, or provider: _____
Organization: _____
Address: _____

❑ Health Records	❑ Counseling and Therapy Notes and Reports
❑ Medical Reports and (including related services)	❑ Psychotherapy Notes
❑ Chemical Abuse/Dependency Reports	❑ Medical History Reports
❑ Psychological Reports	❑ Laboratory Reports
❑ Psychiatric Reports	❑ Social Worker Reports
❑ Discharge Summaries	❑ Others (specify):_____

The following information requires special consent by law. Even if you indicate all health/medical information, you must specifically request the following information in order to be released:

❑ Chemical Abuse/Dependency Report ❑ Psychotherapy notes (this consent cannot be combined with any other)

To the following individual(s)/entity(ies): Name:_____Title:_____

Organization:_____ Telephone Number:_____

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Discussion of Data. By signing this Authorization, I am also authorizing the District (including its employees and representatives) and the above-named individual, entity, or health care provider (including its employees and representatives) to discuss confidential or private data that they maintain on my child.

How Information May Be Used and Access to Information. I understand that the District will use the information that it receives to coordinate services related to the education of my child. I also understand that the information that is provided to the District may be shared with, and disclosed to, District employees and representatives who have a need to know the information in order to perform their job duties and to others, if specifically authorized by law.

Effective Date and Revocation. This Authorization takes effect on the date I sign it and will automatically expire in one calendar year, unless I exercise my right to revoke the Authorization, in writing, on an earlier date. I understand that I can revoke this authorization at any time by sending a written revocation to: _____.

Medical Treatment or Payment Not Conditioned on Signing. I understand that the healthcare provider named above may not condition treatment for my child or payment on whether I execute this authorization. The information disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act (HIPAA").

Voluntary. I understand that I am not legally required to sign this document. If I choose not to sign this document, I understand that the District may be required to make decisions without the benefit of information that the above-named health care provider, entity, or individual could have provided.

Copies. A copy of this authorization has the same legal effect as the original and is as valid as the original.

_____ Date: _____

Parent/Legal Guardian