

### CONSENT FOR MUTUAL EXCHANGE OF INFORMATION

Student name \_\_\_\_\_ Student # \_\_\_\_\_ DOB \_\_\_\_\_ Date \_\_\_\_\_  
Serving school \_\_\_\_\_ IEP Mgr \_\_\_\_\_ Grade \_\_\_\_\_ Age \_\_\_\_\_

I hereby authorize the exchange of records between:

\_\_\_\_\_  
*Name of agency/person*

\_\_\_\_\_  
*Staff Name*

\_\_\_\_\_  
*Street Address*

\_\_\_\_\_  
*Staff Position*

\_\_\_\_\_  
*City/State/Zip*

\_\_\_\_\_  
*Phone*

\_\_\_\_\_  
*School*

\_\_\_\_\_  
*Fax*

\_\_\_\_\_  
*Phone*                      *Fax*

**Check all record types to be released:**

- |  |   |
|--|---|
| <input type="checkbox"/> Health records            | <input type="checkbox"/> Psychological and counseling records |
| <input type="checkbox"/> Special Education records | <input type="checkbox"/> Immunization                         |
| <input type="checkbox"/> Evaluations and reports   | <input type="checkbox"/> Other _____                          |

**The reason for exchanging the record(s) is:**

- |   |  |
|---|--|
| <input type="checkbox"/> Eligibility Verification | <input type="checkbox"/> Evaluation/Reevaluation Eligibility Determination |
| <input type="checkbox"/> Educational Placement    | <input type="checkbox"/> Other _____                                       |

The information obtained will be treated in a confidential manner by the school district under the provisions of the Family Education Rights and Privacy Act (FERPA). FERPA prohibits disclosure of personally identifiable information without consent except in limited circumstances. Please note that if the request is for health or medical information, the medical information received is protected under FERPA privacy standards by a school district and not the Health Insurance Portability and Accountability Act (HIPAA).

You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive services. I understand that it is my right to request a copy of all information and contest any information I feel is incorrect.

**This consent and authorization is valid for 60 days from the date of parent/adult student signature.** Consent may be withdrawn at any time in writing, except where information has already been released based upon my authorization.

\_\_\_\_\_  
Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Student (if over age 13 if health records are being requested)