



GLENVIEW SCHOOL DISTRICT 34

1401 Greenwood Road
Glenview, Illinois 60026
www.glenview34.org

Authorization for Use and Disclosure of Protected Education Records and Health Information

Patient/Student Name: _____ Date of Birth: ____/____/____

I hereby authorize: _____

Phone: _____

(insert name, address and phone number of individual authorized to disclose records)

to disclose protected health information and/or educational records to: _____

Phone: _____

(insert name, address and phone number of individual authorized to disclose records)

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All Permanent Records

(including but not limited to basic identifying information, academic transcripts, attendance records, health records and scores received on all State assessments)

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All Temporary Records

(including but not limited to scores on state assessments, discipline and health records, accident reports, test results, report cards, progress monitoring information, special education records, Section 504 records)

If not all records, please select all that apply from the choices below:

Education information:

___ Grades/report cards/transcripts
___ Psychological evaluations
___ Speech and language evaluations/reports
___ Educational testing (local and state)
___ IEP's/504 plans/eligibility documents
___ Health histories
___ Occupational therapy evaluation/reports
___ Physical therapy evaluation/reports
___ Social assessments/histories
___ Neuropsychological evaluations
___ Assistive technology information
___ Behavioral/discipline information

___ Only covering the period of time

from ____/____/____ to ____/____/____

Medical information:

___ Medical history
___ Treatment plans
___ Immunization Records
___ Nursing Assessment
___ School physical forms
___ TB or other lab results
___ Medication records
___ HIV information
___ Lead screening
___ Dental

___ Only covering the period of time

from ____/____/____ to ____/____/____

Mental health information:

___ Treatment plans
___ Psychiatric evaluations
___ Psychological Evaluations
___ Neuropsychological Evaluations
___ Clinical assessments
___ Treatment notes
___ Clinical notes
___ Medication records
___ Discharge summaries
___ Social assessment/history

___ Only covering the period of time

from ____/____/____ to ____/____/____

Substance abuse information:

___ Substance abuse history ___ Discharge/continuing care plan ___ Treatment, attendance placement and progress

This authorization is valid for one calendar year and will expire on _____. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I understand that my revocation of this authorization will not be effective for actions taken by the school district or health care provider in reliance upon my authorization and prior to notice of my revocation. I understand that failing to authorize disclosure of records may adversely impact the educational programming and/or medical treatment for my child. I recognize that health records, once received by the school district, may not be protected by the HIPAA Privacy Rule, but will become education records protected by the Family Educational Rights and Privacy Act. I also understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain health care. I also understand that I have the right to inspect and copy educational records and to challenge their content.

Parent Name (please type)

Parent Signature

____/____/____
Date

Student Signature (If student is over 12 years of age and the authorization is for the release of mental health records)

____/____/____
Date