



STOUGHTON AREA SCHOOL DISTRICT AUTHORIZATION FOR RELEASE OF STUDENT INFORMATION TO NON-PARENT / GUARDIAN

The purpose of this form is to allow the Stoughton Area School District to release student information to specific agencies or individuals.

Student Information:

NAME: _____ DATE OF BIRTH: _____ GRADE: _____

Agency or Individual information is being released to:

NAME: _____ PHONE: _____

ADDRESS: _____

EMAIL: _____

RELATIONSHIP TO STUDENT: _____

The above agency or individual is authorized to have access to information checked below. Student records can be written, verbal, and/or electronic.

☐	"Student Progress Records and Directory Data" (ex. Identifying information, grade level, courses, grades, attendance records, class information, lead screening, immunizations, extra-curricular)	☐	"Law Enforcement Unit Records" (ex. Records maintained by law enforcement unit of the district)
☐	"Behavioral Records" (ex. All records not progress reports, psychological tests, physical health records such as basic health info, emergency medical card, log of first aid/medical administration)	☐	Excuse Student from School Attendance
		☐	Pick Up Student from School
☐	Other (please specify):		

*****For any exchange, or release, of medical information relating to a student's health not listed above or as classified as "Patient Health Care Record" in Wis. Stat. sec. 118.125(2m), a HIPAA Release of Information Form must be used***** Examples are:

- Medical or health reports from health care providers
- Medical diagnoses
- Records of conversations with physicians & other health care providersSummary of evaluation reports written by health care providers in the school that discuss a student's health or medical history
- Individual health care plans, emergency action plans or other treatment plans regarding a student's health developed by health care providers in the school setting (e.g. nurse, OT, PT or physician)
- 504 or other accommodation plans that include medical diagnoses or other supporting documentation by health care providers in a school setting (e.g. nursing diagnoses, medical orders, professional judgments concerning a student's health)
- Medicaid documentation
- Any pupil record containing information about a student's health other than what is identified as a pupil physical record

This authorization will be in effect until rescinded in writing by the parent / guardian signed below

NAME: _____ PHONE: _____

ADDRESS: _____

EMAIL: _____

RELATIONSHIP TO STUDENT: _____ Parent _____ Legal Guardian _____ Adult Student

Signature : _____ Date: _____

Return form to student's school office or the Stoughton Area School District, Office of the District Administrator, 320 North Street, Stoughton WI 53589.

The records, if provided, shall be for the exclusive use of the above named recipient and shall not be published or disseminated in any way unless said recipient obtains written permission of the undersigned. Parent or adult student may have access to pupil records to inspect their contents. (WI Law, Chapter 254 and Federal Law, Tidal V, sec. 438).