PENNRIDGE SCHOOL DISTRICT

Office of Student Services
1200 North Fifth Street
Perkasie, Pennsylvania 18944-2295

AUTHORIZATION FOR EXCHANGE OF INFORMATION

Date:

Student: ______________________________ **DOB:** ______________________

Address: ______________________________ **School:** ______________________

______________________________ **Grade:** ______________________

I (we) the undersigned parents(s)/legal guardian(s) of above student hereby authorize:

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(School/Agency/Individual and Address)

to release copies of records to and communicate with:

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(School/Agency/Individual and Address)

to assist in educational planning. The specific items requested are:

☐ **School reports, academic and discipline records, transcripts, standardized test scores, instructional support intervention and attendance records**

☐ **Complete Special Education Records: Comprehensive Evaluation Reports (MDE/CER), Specialists Reports, IEP, NOREP**

☐ **Psychological, Psychiatric and social worker reports***

☐ **Medical Records, Health Report**

____ **Other Specific Records:**

I (we), the undersigned, hereby acknowledge that I (we) have read this authorization prior to its execution and fully understand the nature of this release. All information released will be handled confidentially and in compliance with federal and state regulations.

This authorization allows the release of confidential information protected under the Health Insurance Portability and Accountability Act ("HIPAA") and the Family Educational Rights and Privacy Act ("FERPA") and is designed to meet the requirements of both laws. I (we) understand that I (we) may revoke this consent at any time, except to the extent that action has already been taken in reliance upon my consent. My consent will expire one (1) year from the date of my signature. I understand that both of the above parties must maintain the information they exchange in the strictest confidence and that they may not re-disclose it except as explicitly permitted under HIPAA or FERPA.

I (we) am signing this authorization voluntarily and understand that my child's receipt of any healthcare treatment or educational service is not contingent upon complying with this request for authorization.

______________________ ______________________________
Date **Parent Signature**

______________________ ______________________________
Date **Parent Signature**

______________________ ______________________________
Date **Student Signature**

***Required of students 14 years and older when requesting mental health information.**