TOLLESON ELEMENTARY SCHOOL DISTRICT

Authorization for the Release of Medical, Educational and other Information

Student Name: _____ **Birthdate:** ____/____/____

Address: _____ **Phone:** _____

_____

I authorize _____
(name of health care provider, agency, or medical institution)
to release evaluation records to _____
(LEA/school district's name)
for the purpose of determining eligibility for special education services and/or provision of Section 504.

********I authorize the Tolleson Elementary School District to share information about student (verbally, in writing, and documents) with the following Agencies, and or Person (s),** _____

_____

District Contact: _____

District Address: _____

I consent to the release of the following health/education information to TESD regarding this child from

____/____/____ to ____/____/____ :

- ☐ Current Medical Status
- ☐ Current Medications/treatments
- ☐ Recommendations for School
- ☐ Other _____

I hereby give special permission to the above named medical entity to release records pertaining to:

- ☐ Mental health
- ☐ Substance abuse/chemical dependence
- ☐ Sexually transmitted disease
- ☐ HIV/AIDS

I understand that the released information becomes a part of the student's educational records and, as such, is protected by the Family Educational Rights and Privacy Act (FERPA). The information may be reviewed by all members of the Section 504 team and, as appropriate, those identified as having legitimate educational interest. The information may also be used in the future, including if the student moves, for the purpose of educational decision making.

I understand that I have the following **rights** with respect to this authorization:

- The right to inspect or copy the health information to be disclosed by this form.
- The right to receive a copy of this form.
- The right to withdraw this Authorization by written notification at any time (although my withdrawal will not be effective as to uses and/or disclosures already made regarding this form).

This authorization is valid until ____/____/____ , or until one year after the date of signing, whichever occurs first.

_____ _____ ____/____/____
Signature Relationship to Student Date

_____
Printed name

Health Insurance Portability and Accountability Act (HIPAA)/
Family Educational Rights and Privacy Act (FERPA) Notice

Any and all personally identifiable information regarding children and families is protected from unauthorized disclosure under FERPA. Personally identifiable information protected by FERPA is specifically **exempted** from HIPAA privacy standards. FERPA prohibits disclosure of personally identifiable information without parent consent except in limited circumstances, requires notice to be provided to the child's family regarding their privacy rights, requires providers to keep records of access to a child's records, and contains complaint and appeal procedures which apply to disputes over records.