Section 504 Authorization for the Release of Health and/or Educational Information

Student Name: _____

Date of birth: ____/_____/_____ **Phone:** _____

Address: _____

Parent/Guardian/Eligible Student: Your signature on this authorization for release of information form will be provided to individuals, programs, organizations, and entities stated below.

Statement of Release

On behalf of the above named student, I authorize _____(name of health care provider, agency, or medical institution) *to release evaluation records to* _____ (School or School District) *for the purpose of determining eligibility for and/or provision of Section 504.*
Building/District Contact: _____ District Address: _____ For this purpose, I consent to the release of the following health information to the identified school district regarding this child from ____/_____/_____ to ____/_____/_____.

I give consent for the following specific information to be exchanged:

❑ Current medical status ❑ Current medications/treatments

❑ Recommendations for school ❑ Other (specify) _____

I give consent to the above named medical entity to release records pertaining to:

❑ Mental health ❑ Substance abuse/chemical dependence

❑ AIDS/HIV ❑ Sexually transmitted disease

❑ Other (specify) _____❑ Other (specify) _____

I give consent for the exchange of information by the methods indicated:

1. The exchange of written records containing the information described in this release by the agencies or individuals specified.

   ❑ Yes ❑ No
2. The verbal exchange of the information described in this release by the agencies or individuals specified.

❑ Yes ❑ No

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).

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

Printed name: _____ Relationship to student: _____

Date ____/_____/_____

Signature: _____