DELAWARE CITY SCHOOLS

CONSENT OF PARENT/GUARDIAN FOR RELEASE OF INFORMATION

For the purpose of providing appropriate instruction and assistance in school, a mutual exchange of information and records is required for your child.

Student Name: _____ **DOB:** _____

School: _____ **Grade:** _____

The requested exchange is between the Delaware City Schools and the following:

_____

_____
(Name and address of: hospital, clinic, physician, institute, association, or school)

Name of Contact Person: _____ Phone: _____

Records that may be exchanged include the following: (check all that apply)

_____ Release all information
_____ Release the checked information:

- _____ General identifying data (name, address, DOB, grade level completed, grades, class standing, attendance record)
- _____ Standardized achievement and aptitude test scores
- _____ Personality and interests scores
- _____ Record of extra-curricular activities
- _____ Individualized education programs (IEP, 504 plans, ETR)
- _____ Psychological reports
- _____ Medical reports
- _____ Psychiatric reports
- _____ Teacher ratings
- _____ Other: _____

Consent of Parent/Guardian for Release of Information:

I authorize the Delaware City Schools and _____ located at _____
(agency/physician) (address)
to exchange information and records as indicated. Except as limited below, this authorization encompasses all information pertaining to the minor, including protecting health information (PHI) as defined in the Health Insurance Portability and Accountability Act (HIPAA) and its implementing regulations, and education records as defined in the Family Educational Rights and Privacy Act (FERPA) and Ohio Revised Code Section 3319.321.

We expressly waive all provisions of law (including, but not limited to, the privacy provisions of HIPAA, FERPA, and R.C. 3319.321), forbidding any physician or other person who has or may hereafter treat, attend, or examine the minor, or any educational agency, from disclosing any knowledge or information, including PHI, which they may have thereby acquired.

Pursuant to HIPAA, the following are specified as part of this authorization:

a. The purpose of disclosure is for assisting the Delaware City Schools (DCS) in offering the student a free and appropriate public education.

b. This authorization expires one (1) year after the date it is signed.

c. The parents signing this permission form understand that they may revoke this authorization at any time by providing written notification to the Director of Student Services or the building principal or the individual and/or organization listed above, except to the extent that this authorization has already been relied upon.

d. The parents signing this form have been informed that the individual and/or organization/agency listed above may not condition treatment, payment, enrollment, or eligibility for benefits on whether the parents sign this authorization.

e. The parents signing this form have been informed of the potential for information disclosed pursuant to this authorization to be subject to redisclosure by the recipient and to be no longer protected by HIPAA. The parents signing this form are also aware that any information disclosed to Delaware City Schools is subject to other state and federal privacy laws.

_____ _____ _____

(Parent Signature) (Relationship to Student) (Date Signed)

Address: _____ Phone: _____

Please send released information to: _____
(name, address, phone number, fax number)

Copies to: ☐ Parent/Guardian ☐ Cumulative Folder ☐ Administration Building ☐ Building 504 Officer

4/07
5/17/10