AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

Student name: _____ Date of Birth: _____

INSTRUCTIONS: Complete one or both of the Authorization Statements below, place checkmarks by the information that may be released by the information that may be disclosed and sign the authorization. In order to allow the exchange information between the Marshall Public Schools and the identified individual/entity, please check both of the Authorization Statements.

AUTHORIZATION STATEMENTS:

☐ I, the undersigned, hereby authorize the Marshall School District to disclose by any means (including written, oral, or electronic means) the information indicated below regarding the pupil to:

Name:	Name:	Name:
Address:	Address:	Address:
Phone:	Phone:	Phone:

☐ I, the undersigned, hereby authorize _____, (insert name of individual, organization, or agency) to disclose by any means (including written, oral, or electronic means) the information indicated below to Marshall Public Schools:

INFORMATION TO BE DISCLOSED:

Education Information/Records	**Health Information/Records**	
☐ Progress Records	☐ Patient Health Information	☐ Alcohol/Drug Abuse Records
☐ Behavioral Records	(specify or indicate "all")	☐ Mental Health Records
☐ Pupil Physical Health Records	_____	☐ Development Disabilities
☐ Psychological Records	_____	☐ HIV (AIDS) Records
☐ Special Education Records	_____	☐ Other (specify):
☐ Outside Agency Records	_____	_____
☐ Law Enforcement Records	_____	_____

PURPOSE OF DISCLOSURE: The information is requested for the purpose of educational programming and service, medical evaluation and treatment, health assessment and planning, or other (specify, such as "at request of individual")_____

_____

ACKNOWLEDGEMENTS: **Receive Records & Authorization** – I understand that I have a right to a copy of the records that are disclosed and a right to a copy of this authorization. **Withdrawal of Authorization** – I understand that I have the right to revoke this authorization, except to the extent that disclosure has already been made in reliance on this authorization. I understand that my revocation is effective only if it is in writing and it is submitted to the individual/entity that is releasing information. **Re-Disclosure of Health Information** – I understand that if my child's health information is released pursuant to this authorization, it may be subject to re-disclosure by a person who received health information and may not be protected by federal law. **Voluntary Authorization** – I understand that a health care provider may not condition healthcare treatment, payment or eligibility for health plan benefits of whether or not I sign this authorization.

This permission is valid for one year from the date signed. A copy of this form is as effective as the original: I certify that I am the parent, legal guardian, personal representative of the above named pupil or that I am the pupil and of majority age, and have the authority to sign this release.

_____ _____

Signature Date

_____ _____

Print Name Relationship to Pupil (parent, guardian, personal representative or adult pupil)

☐ Check here if you are requesting a copy of education records disclosed by Marshall Public Schools (a fee for education record copies may be imposed).