South Vermillion Community Schools

CONSENT FOR RELEASE OR EXCHANGE OF INFORMATION

Records are requested on the following individual:

Student's Name	Date of Birth	School
Student's Street Address	City/State/Zip Code	Phone

South Vermillion Community Schools is reviewing the education program for the individual listed above. Information from other agencies/organizations is needed for this process.

I authorize and give consent to South Vermillion Community Schools and its employees to release to and/or exchange with the organization(s)/person designated below. I understand that educational, medical, substance abuse, mental health, HIV information, and records of confidential communications may be contained in the records being released. I understand this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Organization/Person	Address	Phone

I authorize and consent the following information to be released and/or exchanged:

- ☐ Biopsychosocial History
- ☐ Individual Psychological Evaluation
- ☐ Psychiatric Evaluation
- ☐ Admission Summary
- ☐ Discharge Summary
- ☐ Medical Records
- ☐ Standardized Achievement Evaluation
- ☐ Personality Evaluation
- ☐ Speech/Language/Hearing Evaluation
- ☐ Teacher Ratings
- ☐ Individualized Education Program
- ☐ Record of Ancillary Services
- ☐ Probation Report
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____

Specific purpose of the use or disclosure:

This consent is for records of services or communications beginning _____ (month) _____ (year)

This consent, unless revoked earlier in writing, expires _____. This consent will last no longer than one calendar year.

I understand that health care providers will not require my signature on this consent to be a condition of treatment or payment. I understand that I may generally revoke this authorization at any time by notifying the health care provider in writing. However, I may not revoke this authorization to the extent that the health care provider has taken action in reliance upon the authorization.

I understand my rights and hereby authorize the use or disclosure of my individually identifiable health/educational information as set forth herein.

Signature of Parent/Guardian: _____ Date: _____

Student: _____ Date: _____

Witness (Required): _____ Date: _____