Authorization to Exchange Confidential Information

Date: ________________

Name: ________________________________ ID# ________________________________

Date of Birth: ____/____/________ Age: ______ School: ____________________________ Grade: __________

Parent(s)/Caregiver(s): ____

Street Address: ______________________________________ City: ________________ Zip: ______________

Home Phone: (______) ______-________ Work Phone: (______) ______-________

Cell Phone: (______) ______-________ Native Language: ____________________________

I understand and agree that in order for my school-age child to receive care and/or services that will help him/her to function most successfully in the school environment, professionals working to assist him/her will need to exchange information so that plans, strategies, and accommodations can be coordinated and sustained. I hereby authorize these agencies or service providers: *

____________________________________ ____________________________________

____________________________________ ____________________________________

____________________________________ ____________________________________

____________________________________ ____________________________________

to exchange the following information in order to provide coordinated support to my child:

- ☐ Assessment results
- ☐ Results of psychological testing
- ☐ Medications prescribed
- ☐ Diagnosis
- ☐ Provider name
- ☐ Appointment schedule/attendance
- ☐ Suggestions for school supports
- ☐ Discharge summary/release to return to school
- ☐ Substance abuse information
- ☐ Court reports/orders
- ☐ Medical conditions/on-going treatment (not including HIV/AIDS)
- ☐ Results of educational testing
- ☐ Classroom observations
- ☐ Discipline records
- ☐ Special Education records
- ☐ School progress information
- ☐ School attendance information
- ☐ School behavior plan
- ☐ Promotion/placement information
- ☐ Intervention Team actions/reccomendations
- ☐ Family and Child Team case plan/progress reports
- ☐ Other ______________________________

*** Person completing this form with student/family should distribute copies to all agencies/individuals named in this section.**

Authorization continued on reverse size of this form.

Information released under this exchange of information authorization will be used for the following purpose(s):

- ☐ Support school success
- ☐ Continuity of care
- ☐ Coordination of agencies/services
- ☐ Legal proceedings
- ☐ Treatment/goal Planning
- ☐ Assessment/evaluation
- ☐ Determination of benefits
- ☐ Discharge/aftercare Planning

☐ Other ____________________

I understand that:

Authorizing this exchange of information is voluntary and that if I choose not to authorize any exchange of information, my services will not be affected.

I may withdraw this consent in writing at any time to limit any future exchanges of information.

All parties who receive any information under this authorization are bound by confidentiality laws and regulations and have signed confidentiality agreements with each other.

This release is for a period of one year from the date it is signed unless otherwise indicated here: ____________________

Student Signature ____________________ Date ____________________

Printed Name of Parent/Guardian ____________________ Relationship to Student ____________________

Parent/Guardian Signature ____________________ Date ____________________

Printed Name of Person Facilitating Completion of Authorization ____________________

Signature of Person Facilitating Completion of Authorization ____________________ Date ____________________

Notice of Withdrawal of Authorization for Information Exchange

I withdraw my authorization for further exchange of the information previously released by my signature on the "Authorization for Exchange of Confidential Information" form on ____________ (Date) effective immediately.

Printed Name of Parent/Guardian ____________________ Relationship to Student ____________________

Signature of Parent/Guardian ____________________ Date ____________________