Medford Area Public School District

Permission To Obtain *And* Release Information

Date: ___________________________

Dear ____,

In order for us to **exchange/obtain/release** ***(circle one)*** information regarding your child, please complete and return one copy in the self-addressed, stamped envelope that is included and keep the other copy for your files. If you have any questions, contact me at 715-748-4620.

Sincerely,

____
Contact Person

AUTHORIZATION

Student Information	Student Name	D.O.B.	Gender
	Address	Daytime Phone Number	
	City	State	Zip
Who has the information that is to be released?	Name	Phone Number	
	Address	Fax	
	City	State	Zip
Whom should the information be released to?	Name Medford Area Public School District	Phone Number 715-748-4620	
	Attention Director of Special Education	Fax 715-748-6839	
	Address 124 W. State Street	City, State Medford, WI	Zip 54451
Reciprocal Exchange Between			

- ☐ Official student academic/administrative records (identifying information, grade level completed, grades, class rank, attendance records, and group aptitude and achievement test results).
- ☐ Medical and/or related health records.
- ☐ Psychological evaluations or social work reports.
- ☐ Evaluations and related reports.
- ☐ Appropriate agency reports.
- ☐ Individualized education plans.
- ☐ Verbal exchange.
- ☐ Reading, Math, Behavioral, and Intervention Records.
- ☐ Others (specify)____.

The purpose of this request is to assist in the educational evaluation and program planning; health assessment and planning for health care services and treatment in school; and medical evaluation and treatment of your child.

Expiration: This Authorization will remain in effect:

- ☐ From the date this authorization is signed until the ______ day of ______________, 20____.
- ☐ Until you cancel this authorization in writing.
- ☐ Until the following event occurs, specify event ___________________________________.
- ☐ Other, specify ____.

Comments: ____

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I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent and that the written revocation must be given to the agency/organization I authorized to release information. I recognize that health records, once received by the school district, may not be protected by the HIPPA Privacy Act and may become education records protected by the Family Educational Rights and Privacy Act (FERPA) with additional protection afforded by Wisconsin Statutes 118.25(2m)(a)(b) and 146.82-146.83. I also understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain health care.

______________________________________	__________________________	____________
Signature of Parent or Legal Guardian	*Relationship to Child*	*Date*

Send two unsigned copies to parent, including original, and keep one copy for student record; when signed copy is returned, add to student record.

Redisclosure of student record information by receiving agencies is prohibited without prior consent of the parent/adult student.