DeForest Area School District
DeForest, WI 53532

PERMISSION TO OBTAIN AND RELEASE INFORMATION

(Name of Student) _____ (Date of Birth) _____

(Street Address) _____ (City, State, Zip Code) _____

☐ **DISCLOSURE TO DEFOREST AREA SCHOOL DISTRICT**. I authorize [name, address and phone of person or organization releasing information]

_____

_____

to disclose the information indicated below, by any means (including both written and oral communication), to [name, address and phone of school official] _____

☐ **DISCLOSURE BY SCHOOL DISTRICT**. I authorize the **DeForest Area School District** to disclose the information indicated below, by any means (including both written and oral communication), to:

Name: _____ Name: _____

Address: _____ Address: _____

_____ _____

Phone: _____ Phone: _____

Information to be released [check all that apply]:

Education Records	**Dates of Service:**	**Health Records**	**Dates of Service:**
☐ Progress records	_____	☐ All (or specify below)	_____
☐ Behavioral Records	_____	☐ Specific records (describe)	_____
☐ Pupil Physical Health Records	_____	_____	
☐ Special Ed. ☐ **All**	_____	_____	
or as follows ☐ IEPs	_____	_____	
☐ Evals.	_____	_____	
☐ Social Work	_____	_____	
☐ Other _____	_____	_____	

Purpose(s) of Disclosure:

☐ Educational Evaluation and Programming
☐ School Related Health Planning
☐ Medical Evaluation and Treatment
☐ Request of Pupil or Parent/Guardian
☐ Transfer of Education Records
☐ Other: _____

PLEASE REVIEW AND ACKNOWLEDGE YOUR UNDERSTANDING OF YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

I have reviewed this form and I understand and acknowledge that:

- I have the right to inspect or copy the information I have authorized to be disclosed by this authorization form.
- I am under no obligation to sign this form and my refusal to sign will not affect treatment, enrollment or benefits for me or my child.
- The information that I authorize to be released may be redisclosed by the recipient of the records if allowed by law. If information is redisclosed, the recipient of the redisclosed information may be controlled by different laws. Once received by the school district, records may no longer be protected by the HIPAA Privacy Act and may become education records protected by the Family Educational Rights and Privacy Act (FERPA) and/or Wis. Stat. § 118.125.
- I have the right to receive a signed copy of this form.
- This authorization is valid for one year, and covers records created after I sign this form, unless I revoke the form sooner. I may revoke this authorization, in writing, at any time. However, the revocation will not affect disclosures that occur before my revocation.

I acknowledge that this authorization specifically includes disclosure of information regarding psychiatric consults and mental illness, alcohol or drug treatment, developmental disabilities, AIDS or AIDS-related illness, and/or HIV test results, with the following exception(s):

_____

I acknowledge that I have had an opportunity to review and ask questions about this form and that I understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes. A copy of this form is an effective as the original.

I hereby authorize disclosure of records to the named persons or entities, as specified above.

SIGNATURE – If Pupil is a minor, for Parent, Guardian or Other Person Legally Authorized to Consent to Disclosure, state relationship to Pupil	**Date Signed**
SIGNATURE – Minor Pupil (only if legally required)	**Date Signed**

Form created 12-01-2013 JH/DPP