South Bend Community School Corporation
Special Education Department
215 S. Dr. Martin Luther King Jr. Blvd, South Bend, IN 46601
Ph: 574.393.6119 Fax: 574.283.8105

Authorization for Release of Medical and Educational Information and Records

Student Name: ____ Date of Birth: _____________
Student ID:____________ School: __________________________ Grade: _______________

I authorize the **South Bend Community School Corporation** and the **Agency** listed below to exchange the medical and/or educational information and records (described more particularly below) regarding the above-named student to one another:

Contact Person: __________________________________
South Bend Community School Corporation
School: __________________________________
Tel: _______________ Fax: _______________

Agency: ____________________________ Contact Person: ____________________________
Address: ____
Phone: ____________________________ Fax Number: ______________________________

Records to be Released by SBCSC: Please identify the type of records to be released from the SBCSC to the Agency.

- ☐ Medical and health records
- ☐ Mental health records
- ☐ Psychiatric evaluations/reports
- ☐ Psychological evaluations/reports
- ☐ Drug/alcohol records
- ☐ Social work reports
- ☐ Speech/language records
- ☐ Occupational and/or physical therapy records
- ☐ Correspondence
- ☐ Grades, transcripts, course performance
- ☐ Test scores
- ☐ Attendance records
- ☐ Disciplinary records
- ☐ Scholarship and grant applications
- ☐ Special education records, including an Individualized Educational Plan (IEP)
- ☐ Teacher, counselor, staff observations, ratings, and recommendations

☐ Other (please describe): ____
____
____

Unless otherwise noted above, the records to be exchanged are those created between __________(month/year) and __________(month/year).

Records to be Released by Agency: Please identify the type of records to be released from the Agency to the SBCSC.

- ☐ Medical and health records
- ☐ Mental health records
- ☐ Psychiatric evaluations/reports
- ☐ Psychological evaluations/reports
- ☐ Correspondence
- ☐ Drug/alcohol records
- ☐ Social work reports
- ☐ Speech/language records
- ☐ Occupational and/or physical therapy records

☐ Other (please describe): ____
____
____

Unless otherwise noted above, the records to be exchanged are those created between
___________________ (month/year) and _________________ (month/year).

Purpose of Disclosure: The purpose of this disclosure is to:
____
____
____
____

Authorization for Release of Protected Health Information

Please initial next to each paragraph below in order to allow the release of the protected health information described on page one (1) from the Agency listed above to the South Bend Community School Corporation under the Health Insurance Portability and Accountability Act of 1996.

Initial Below

__________ I understand that the information provided may include, when applicable, information relating to communicable diseases such as sexually transmitted disease, Human Immunodeficiency Virus (HIV Infection, Acquired immune Deficiency Syndrome, or AIDS Related Complex) and any other communicable disease. It may also include information about behavioral or mental health services, and referral and/or treatment for alcohol and drug abuse.

__________ I understand that if I give permission, I have the right to change my mind and revoke it. The revocation must be in writing and delivered to the Agency listed above. I also understand that such revocation will not affect any uses or disclosures already made with my permission. I further understanding that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

__________ I understand that unless otherwise revoked by me, this authorization will expire on the following date, event, or condition. If I fail to specify an expiration date, event, or condition, this authorization will expire one year from the signature date.

- ☐ One year after the student is no longer enrolled in a SBCSC school
- ☐ Other: ____

Please specify expiration date, event, or condition

__________ I understand that authorizing the disclosure of this health information is voluntary. I need not sign this authorization to ensure healthcare treatment; except, however, if my treatment is for the sole purpose of creating health information for disclosure to the SBCSC, the Agency listed above may refuse to treat me if I do not sign this authorization.

__________ I also understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and that the protected health information disclosed pursuant to this authorization is no longer protected by federal or state privacy rules. I also understand that the confidentiality of this information when released to a public educational agency, including the SBCSC, is protected as a student record under the

Family Educational Rights and Privacy Act and may only be disclosed as permitted by that Act. I further understand that I may request a copy of this signed Authorization.

Signature: ____ Date:_______________

Relationship to Student (circle one): Parent Legal Guardian Student (if age 18)

Authorization for Release of Education Records

Please initial next to each paragraph below in order to allow the exchange of the student education records described on page one (1) between South Bend Community School Corporation and the Agency listed above under the Family Educational Rights and Privacy Act.

Initial Below

__________ I understand that I have the right not to consent to the release of my child's educational records.

__________ I understand that I have the right to receive a copy of such records upon written request to the South Bend Community School Corporation.

__________ I understand that if I give permission, I have the right to change my mind and revoke it. The revocation must be in writing and delivered to the South Bend Community School Corporation. I also understand that such revocation will not affect any uses or disclosures already made with my permission.

__________ I understand that unless otherwise revoked by me, this authorization will expire on the following date, event, or condition. If I fail to specify an expiration date, event, or condition, this authorization will expire one year from the signature date.

- ☐ One year after the student is no longer enrolled in a SBCSC school
- ☐ Other: ____

  Please specify expiration date, event, or condition

Signature: ____ Date:_______________

Relationship to Student (circle one): Parent Legal Guardian Student (if age 18)

THIS INFORMATION IS RELEASED SUBJECT TO THE CONFIDENTIALITY PROVISIONS OF THE FAMILY EDUCATION RIGHTS PRIVACY ACT (FERPA) AND OTHER APPROPRIATE STATE AND FEDERAL LAWS AND REGULATIONS WHICH PROHIBIT DISCLOSURE OF EDUCATIONAL INFORMATION WITHOUT THE SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS, OR AS OTHERWISE PERMITTED