AUTHORIZATION TO RELEASE RECORDS AND EXCHANGE INFORMATION

Student Name:	
Student Date of Birth:	

I give consent to the Rice Lake Area School District to disclose the pupil records and/or to exchange information verbally and/or in writing as specified below pursuant to WI Stat. § 118.125 and the Family Educational Rights and Privacy Act (34 C.F.R. 99.30). I understand that my consent is voluntary.

Name of Agency to whom disclosure will be made:			
Contact Person (if applicable):			
Address:			
Phone:		Fax:	
Purpose of Disclosure:			
I authorize the following method(s) to disclose and exchange pupil record information (check all that apply):		☐ Written documents	☐ Verbal exchange

The specific information to be released and/or exchanged is (check all that apply):

☐Progress Records (including grades, test results, attendance records, transcripts, enrollment, immunizations, courses taken and co-curricular activities) ☐Behavior Records (including test results, disciplinary records, English Language Learners (ELL) records, 504 plans, psychological test results, special education records) ☐Student Health Records (including accident/injury reports, health screening records, individual health plans, vision screening, physical cards, lead testing records)	Patient Health Records (check all that apply): ☐General Patient Health Records ☐Mental Health Records ☐Alcohol/Drug Abuse Records ☐HIV (AIDS) Records ☐Other (specify) _____ Special Education Disclosure: ☐Individual Education Programs (IEPs) ☐Participation in Individualized Education Program (IEP) Meetings	Other (check all that apply or specify): ☐Psychological Records ☐Agency Reports (such as Dept. of Children and Families or law enforcement records) ☐Written communication ☐ Other (specify) _____ _____ _____ _____
Time period for which records are requested: _____ to _____ or ☐Entire Enrollment		

I further understand that:

1. I have a right to a copy of the records that are disclosed and a right to a copy of this authorization (a fee for education record copies may be imposed).
2. I have the right to revoke this authorization, except to the extent that disclosure has already been made in reliance on this authorization. I understand that my revocation is effective only if it is in writing and it is submitted to the agency that is releasing information.
3. If my child's health information is released pursuant to this authorization, it may be subject to re-disclosure by a person who receives the health information and may not be protected by federal law.
4. A health care provider may not base health care treatment, payment or eligibility for health plan benefits on whether or not I sign this authorization.

This authorization is valid until June 30 of the current school year unless revoked as described above. A copy of this form is as effective as that of the original. I certify that I am the Parent/Legal Guardian of the

student, or that I am the student and of majority age, and have the authority to sign this release.
5. Patient health care records maintained by schools are considered education records and are thus subject to the Family Education Rights and Privacy Act (FERPA) rules, and not the privacy portions of HIPAA.

Signature of Parent/Legal Guardian: _____ Date: _____
Print Name: _____ Relationship to Student: _____
Signature of Student:_____ Date: _____
(if age 18 or older)

School Use Only:
☐ Filed in Cumulative Folder
☐ Filed in Patient Health Care Folder (if patient health records requested)

Adopted: 12/09/19
Revised:
Reviewed: