BURLINGTON-EDISON SCHOOL DISTRICT

AUTHORIZATION FOR EXCHANGE OF INFORMATION

Purpose: As a parent, guardian or student, you have the right to give permission or not give permission for the release of your child's records with another person's or agencies. This request provides you with the opportunity to approve or not approve such a request unless release of records is allowed under one of the exceptions under the rules implementing the Family Eduacation Rights and Privacy Act.

Student Name:_____ Date of Birth:_____

I hereby authorize the exchange of information between:

Name/Agency	_____		Name/Agency	_____
Address:	_____	and	Address:	_____
Address:	_____		Address:	_____
City, State, Zip Code	_____		City, State, Zip Code	_____

I hereby authorize the exchange of information between:

Description of Records Request:

- ☐ All
- ☐ Oral exchange
- ☐ Other (please describe) _____

Reason for Record Request: _____

I understand that this information obtained will be treated in a confidential manner by the school district under the provision of the Family Education Rights and Privacy Act (FERPA). FERPA prohibits disclosure of personally identifiable information without consent except in limited circumstances, such as transfer to another school district where the student is enrolled. Please note that if the request is for health or medical information, the medical information received by the district is protected under FERPA privacy standards and not Health Insurance Portability and Accountability Act (HIPAA). Health and medical records received are not redisclosed by the District.

This authorization is valid from _____ to _____

Note: For release of medical records, the authorization can be no longer than the last day of school

Minors: A minors patient's signature is required in order to release that following information: 1) conditions relating to reproductive care including, but limited to, birth control and pregnancy-related services and sexually transmitted diseases, including HIV/AIDS, (age14 and older) and 2) sustance abuse diagnosis or treatment and mental health conditions, (age 13 and older).
I specifically authorize/consent Burlington-Edison School District to obtain/release health information checked below:
☐ Mental Health/Illness, ☐ Alcohol/Drug Abuse, ☐ Sexuallyu Transmitted Disease (Incl. HIV/AIDS), ☐ Reproductive Care

_____ _____

Signature of Minor **Date**

I understand that my consent for the release of records is voluntary and I can withdraw my consent at any time in writing. Should I withdraw my consent, it does not apply to information that has already been provided under the pior consent for relase.

_____ _____

Parent/Guardian Signature **Date**