



## Authorization For Exchange Of Information

Student Name: \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
 \_\_\_\_\_

**Parent/Guardian/Eligible Student** (over 18, own guardian): Your signature on this *Authorization for Exchange of Information* will give the individuals, programs, organizations, and entities listed on Page 2 of this *Authorization* permission to exchange the information indicated below.

The purpose for the exchange information is: \_\_\_\_\_  
 \_\_\_\_\_

**Your signature will give your permission for the following specific information to be exchanged:**

- Medical Status  Current Medications/treatments  
 Recommendations for School  Other \_\_\_\_\_

**Information in the following areas may not be exchanged without your special permission. Your signature will give your special permission for the exchange of information in the areas indicated:**

- Mental health  Substance abuse/chemical dependence  
 Sexually transmitted disease  HIV/AIDS

**Your signature will give your permission for the exchange of information by the methods indicated:**

- Yes  No The *exchange of written records* containing the information described in this release by the agencies or individuals specified  
 Yes  No The *verbal exchange* of the information described in this release by the agencies or individuals specified

**Before giving your permission for exchange of information, please carefully review the following:**

This authorization is good until the following date, \_\_\_\_/\_\_\_\_/\_\_\_\_, or until one year after the date of signing, whichever occurs first. You may revoke this authorization, in writing, at any time, however, this does not affect information shared prior to your request for revocation. All members of the IEP team and, as appropriate, those identified as having legitimate educational interest may review the information received. The information may also be used in the future, including if the student moves, for the purpose of IEP decision making.

**Health Insurance Portability and Accountability Act (HIPAA)/Family Educational Rights and Privacy Act (FERPA) Notice.** Any and all personally identifiable information regarding children receiving special education services funded under the Individuals with Disabilities Education Act (20 U.S.C. §1400 et seq.) is protected from unauthorized disclosure under FERPA. Personally identifiable information protected by FERPA is specifically **exempted** from HIPAA privacy standards. FERPA prohibits disclosure of personally identifiable information without parent consent except in limited circumstances, requires notice to be provided to the child's family regarding their privacy rights, requires providers to keep records of access to a student's records, and contains complaint and appeal procedures which apply to disputes over records in possession of special education or its providers, among other provisions. All special education providers comply with these procedures.

**If you have questions, please contact:**

Contact person: \_\_\_\_\_ District/Agency: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ e-mail: \_\_\_\_\_

Student Name: \_\_\_\_\_ Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

I understand my rights related to this exchange of information. As per the conditions described on Page 1 of this *Authorization for Exchange of Information*, I consent to the exchange of information with the \_\_\_\_\_ (enter number) individuals, programs, organizations, and entities listed below.

\_\_\_\_\_  
Signature of Parent, Guardian or Eligible Student \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Date

1. Name:	2. Name:
Agency/Relationship:	Agency/Relationship:
Address: _____ _____	Address: _____ _____
Phone:	Phone:
Fax:	Fax:

3. Name:	4. Name:
Agency/Relationship:	Agency/Relationship:
Address: _____ _____	Address: _____ _____
Phone:	Phone:
Fax:	Fax:

5. Name:	6. Name:
Agency/Relationship:	Agency/Relationship:
Address: _____ _____	Address: _____ _____
Phone:	Phone:
Fax:	Fax: