PERMISSION TO OBTAIN AND RELEASE INFORMATION

Name of Child: ________________________ Date of Birth: _____________

Parent/Guardian Permission to Obtain and Release Information I, the undersigned, hereby request and authorize Ripon Area School District Personnel: District RN and/or school staff
Contact Person: District RN and/or school staff

Phone: (920) 748-4633 Fax: (920) 748-4620
Address: 850 Tiger Drive, Ripon, WI 54971

To release, exchange, and obtain information from:

Name of Organization Providing information: ___________________________________

Contact Person Name :__________________ **Phone:** _____________ **Fax:** _____________

Mailing Address:____

Street/City/State/Zip Code ____

The information indicated below (Check all that apply):

- ☐ Official student academic/administrative records (identifying information, grade level completed, grades, class rank, attendance records, and group aptitude, and achievement test results.)
- ☐ Medical and/or related health records. Type of provider: __________________
- ☐ Medical history/diagnostic/therapeutic information
  - ☐ Developmental/Learning Disability ☐ Mental Health ☐ Behavioral Health
  - ☐ Drugs/Alcohol Abuse ☐ HIV
- ☐ Verbal exchange with: ______________________________________
- ☐ Medical information limited to:____
- ☐ Psychological evaluations or social work reports
- ☐ Evaluation and related reports
- ☐ Appropriate agency reports
- ☐ Exchange/release of IEP documents, attendance, participation, development and/implementation of the IEP
- ☐ Other (specify): ____

Purpose of disclosure: ☐ Student Evaluation ☐ Ongoing care/collaboration ☐ Other__________

This permission is valid for one year from the date signed. A copy of this form is as effective as the original.

I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent and that the written revocation must be given to the agency/organization I authorized to release information. I recognize that health records, once received by the school district, may not be protected by the HIPPA Privacy Act and may become education records protected by the Family Educational Rights and Privacy Act (FERPA) with additional protection afforded by Wisconsin Statues 118.25(2m)(a)(b) and 146.83. I understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain health care.

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Signature of parent or legal guardian **Date**

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Signature of Ripon Area School District Health Care Provider **Date**