Authorization for Release of Information

Date: _____

Special Services Office
Luverne Public Schools
709 North Kniss
Luverne, MN 56156
Telephone: (507) 283-4491
Fax No. (507) 283-9681

Student's Name: _____
Date of Birth: ___/___/___ (mm/dd/yy) ID: _____ Grade: _____
School: _____

Name: _____ authorizes District # _____

☐ to release the specific information identified below *to*:

☐ to obtain specific information identified below *from*:

Name of individual or entity: _____

Address: _____

_____

☐ Health Records	Created between ___/___/___ (mm/dd/yy) and ___/___/___(mm/dd/yy)
☐ Medical Reports	Created between ___/___/___ (mm/dd/yy) and ___/___/___(mm/dd/yy)
☐ Chemical Abuse/ Dependency Report	Created between ___/___/___ (mm/dd/yy) and ___/___/___ (mm/dd/yy)
☐ Psychological Reports	Created between ___/___/___ (mm/dd/yy) and ___/___/___ (mm/dd/yy)
☐ Psychiatric Report	Created between ___/___/___ (mm/dd/yy) and ___/___/___ (mm/dd/yy)
☐ Teacher, Counselor, Staff Observations	Created between ___/___/___ (mm/dd/yy) and ___/___/___ (mm/dd/yy)
☐ Special Education Records	Created between ___/___/___ (mm/dd/yy) and ___/___/___ (mm/dd/yy)
☐ Social Work Report	Created between ___/___/___ (mm/dd/yy) and ___/___/___ (mm/dd/yy)
☐ Others *(specify)*	Created between ___/___/___ (mm/dd/yy) and ___/___/___ (mm/dd/yy)

For the purpose of :

_____

_____

_____

I understand this authorization:

- ☐ takes effect the day I sign it,
- ☐ cannot exceed one year, and expires either:
  - ☐ on ___/___/___ (mm/dd/yy), or
  - ☐ one year from the date of my signature,
- ☐ can be stopped any time by sending a written request to:

_____

_____

_____

_____

I further understand:

- ☐ I may refuse to sign this authorization and it will not affect my child's ability to receive educational services,
- ☐ the laws that protect the information identified on this release, in some situations, may allow or require this entity to re-disclose this information, but only as permitted by law Health Insurance Portability and Accountability Act [HIPAA], Family Educational Rights and Privacy Act [FERPA], Minnesota Government Data Practices Act [MGDPA or Chapter 13]),
- ☐ a copy of this release form is as valid as an original, and
- ☐ I will receive a copy of this authorization.

Signature: _____ Date: _____

Parent, legal representative or student (mm/dd/yy)