



RELEASE OF CONFIDENTIAL INFORMATION AND RECORDS

Student Name: _____ Date of Request for Information/Records: _____
Date of Birth: _____ Age: _____ District/School: _____

PROVIDER

We are requesting the specified information and records from:

Name: _____ School/Agency: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Telephone: _____ Fax: _____

PURPOSE

The information and records are requested for the following purpose:

Determination of special education eligibility Other (specify): _____
Development of Individualized Education Plan Other (specify): _____
Coordination of services and ongoing care/education Other (specify): _____

REQUEST

Requesting	Initials	Information/Record Type
		Diagnosis and additional information
		Ongoing two-way written communication
		Ongoing two-way verbal communication
		Most recent progress reports and notes
		Most recent evaluation team and diagnostic findings
		Other:
		Other:

RECIPIENT

We request that the indicated information and records be **sent to**:

Name: _____ Position: _____
BERRIEN RESA **PHONE: 269.471.7725**
P.O. BOX 364 **FAX: 269.471.4048**
BERRIEN SPRINGS, MI 49103

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CONSENT

My signature below means:

- I understand that my authorization is voluntary and that I may withdraw it any time without penalty. Revocation must be in writing and is not retroactive.
- I understand that information about my child will also be kept on a database that is subject to the same confidentiality provisions.
- I understand the confidentiality of information about my child is protected by state and federal law including the Individuals with Disabilities Act (IDEA), the Family Educational Rights and Privacy Act (FERPA), and the Health Insurance Portability and Accountability Act (HIPAA). The protected health information (PHI or personally-identifiable information (PII) in my child's records may not be disclosed, given, sold or transferred in any way to any other agency or program not specified in this release unless otherwise specified by federal or state laws.
- I understand that certain directory information may be disclosed to the school district for purposes of contacting parents about potential preschool services, but that the school district may not re-disclose this information to others without prior written parental consent under IDEA and FERPA.
- I understand that disclosing of health information is voluntary and that I may refuse to sign this authorization without affecting my ability to obtain treatment and services, payment for services or eligibility for services unless this information is needed to meet eligibility or enrollment criteria.
- I have read and understand this consent, or had it read to me in a language that I understand, and I choose one of the following:

I hereby authorize the release of initialed information to the agencies designated and their representatives to engage in verbal, electronic or written communication in order to share records and information listed above for **one year from the date listed below**.

I **do not** authorize any information to be shared at this time.

Signature of Consenting Party:

Date:

Signed by: Parent Legal Guardian Student (must be at least 18)

Signature of Witness:

Date: