Educational Service Unit #1

"Providing Innovation, Leadership and Service"

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Dr. Bill Heimann, Administrator

SERVING: CEDAR ◦ DAKOTA ◦ DIXON • KNOX • THURSTON • WAYNE COUNTIES

AUTHORIZATION FOR RELEASE OF INFORMATION

Date _____ Student's Name _____

DOB _____ Age _____

Address _____

This Individual Authorizes: _____

_____

_____

_____

To Disclose to: _____

_____

_____

_____

The following information (i.e., records, describe nature of information from any physician, hospital, school, clinic, agency or institution having medical, psychological, school or social records):

_____

I understand that my records are protected under the Federal Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it (i.e. probation, parole, etc.)

List any special condition or qualification of this consent form: _____

_____

_____ _____

Parent/Guardian or Authorized Representative Relationship

_____ _____

School Official Signature Title

Clear Data