Authorization for Disclosure of Confidential Student Records

Name of Student:_____Address: _____

Date of Birth: _____

Information is to be disclosed **by**: _____

Information is to be disclosed **to**: _____

Specific information to be disclosed (*please initial all that apply)*:

____ Educational records or information derived therefrom (*please describe)*: _____

____ Mental health treatment records from (*insert date*) _____ to (*insert date*) _____

____ Special education records

____ Coordination of services records (*please describe*)_____

____ Other (*please describe)*:_____

Purpose(s) of disclosure (*please initial all that apply*):

____ To comply with a request of the parent/person in parental relation or the student (if age 18 or older and competent);

____ To assist with an evaluation or the provisions of services or accommodations by ICSD;

____ To assist in the provision of school counseling services or;

____ Other (*please specify*):_____

Date or event on which this authorization expires (*please initial one*):

____ When the student is no longer an Ithaca City School District student

____ Other specified date or event (*please specify*): _____

Acknowledgements:

I hereby, knowingly, and voluntarily authorize the above-named agency/provider to use or disclose this information only in the manner described above. I understand treatment, payment, and health plan enrollment will not be conditioned on my authorization of this disclosure. I understand that I may revoke this authorization in writing at any time. I understand that if this Authorization allows protected health information to be disclosed to a recipient that is not a health care provider or a health plan, the information disclosed may no longer be protected under the HIPAA Privacy Rule.

PARENT / GUARDIAN SIGNATURE **Date signed:**

_____ _____

_____ _____

Printed name of parent/guardian Relationship to student