PINE ISLAND PUBLIC SCHOOLS 223 1ST AVE SOUTH EAST PINE ISLAND, MN 55902	CONSENT TO RELEASE PRIVATE DATA

Student Name:	ID#:	Date:
School:	Grade:	DOB:

THIS FORM ALLOWS INFORMATION ABOUT YOUR CHILD TO BE EXCHANGED. PLEASE SIGN AND RETURN IT.

Guardian Name:
Guardian Address:

I authorize *(Person Responsible):*
AND **PINE ISLAND PUBLIC SCHOOLS**

CHECK EITHER OR BOTH BOXES, AS NEEDED:

X	**TO RELEASE INFORMATION TO:**
X	**TO OBTAIN INFORMATION FROM:**

CHECK APPROPRIATE BOXES:

	MAYO CLINIC, 200 SW 1ST STREET, ROCHESTER, MN 55905
	OLMSTED MEDICAL CENTER, 210 9TH STREET, SE, ROCHESTER, MN 55904
	OTHER (PLEASE LIST):

SCHOOL RECORDS MAY BE EXAMINED BY GUARDIAN(S), OR STUDENT IF AGE 18 OR OLDER. THE INFORMATION TO BE RELEASED:

	Official School Records (name, address, birth date, gender, attendance record, grade level, grades, class rank, standardized group test results)
	Health Record
	Psychological Reports
	Special Education Records (including related services)
	Teacher, Counselor, Staff Observations
	Chemical Abuse/Dependency Request
	Medical Report (including related services)
	Psychiatric Report
	Social Work Report
	Audiological and/or ENT evaluations and records
	Speech/Language evaluations and records
	Other:

THE PURPOSE FOR THE REQUEST: _____

I understand that this authorization takes effect the day I sign it. It expires on _____ or no more than one year from the date of my signature, whichever is earlier.

I also understand that I may revoke this authorization at any time by providing a signed, written notice of revocation to the Licensed School Nurse of Pine Island Public Schools. A photocopy or facsimile of this Authorization has the same legal effect as the original.

In the case of protected health or medical information, I hereby authorize the healthcare provider to discuss, disclose, and otherwise release any and all medical records, medical data, and heath data identified above to the Pine Island Public Schools and its staff and representatives pursuant to the Health Insurance Portability and Accountability Act ("HIPAA") privacy regulations, 45 C.F.R. § 164.508. I understand that the healthcare provider may not condition treatment or payment on whether I execute this authorization. Health or medical information that is disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by the privacy regulations promulgated pursuant to HIPAA. Records that are received by the School District may be protected from re-disclosure under the Family Education Rights Privacy Act and the Minnesota Government Data Practices Act.

_____ _____

Parent Signature (Student if age 18 or older) (M/D/Y)