BERRIEN RESA
Today's Purpose - Tomorrow's Promise.

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
- ❑ Development of Individualized Education Plan
- ❑ Coordination of services and ongoing care/education
- ❑ Other *(Specify)* _____
- ❑ Other *(Specify)* _____
- ❑ Other *(Specify)* _____

REQUEST

Initials		Requested Information and Records
_____	❑	_____
_____	❑	_____
_____	❑	Diagnoses 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 _____

RECIPIENT

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

Name _____ Position _____

BERRIEN RESA
P.O. BOX 364
BERRIEN SPRINGS, MI 49103

PHONE: 269-471-7725
FAX: 269-471-4048

RELEASE OF CONFIDENTIAL INFORMATION AND RECORDS

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 date listed below.**

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

Signature of Consent _____ Date _____

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

Signature of Witness _____ Date _____

***This form does not permit information about AIDS, ARC, HIV, TB, hepatitis, mental health status or substance abuse to be shared. For these purposes, an Authorization to Share Specific Information must be used.**