Release of Information and Records **Chagrin Falls Exempted Village Schools**

CHILD'S INFORMATION

CHILD'S NAME: _____ ID #: _____ DATE OF BIRTH: _____

SCHOOL: _____ GRADE: _____

RELEASE OF INFORMATION AND RECORDS

In order to ensure your child is provided with equal access (both physical and academic) to services, programs and activities offered by our school, a mutual exchange of information and records is required for your child.

The requested exchange is between the Chagrin Falls Exempted Village School District and the following:

_____ _____

(hospital, clinic, physician, institution, association, or school) Name of Contact Person

_____ _____

Address Phone

Records that may be exchanged include the following (check all that apply):

- ☐ Release all information
- ☐ Release checked information list
  - ☐ General identifying data (name, address, birth date, grade level completed, grades, class standing, attendance record)
  - ☐ Standardized achievement and aptitude test scores
  - ☐ Personality and interest scores
  - ☐ Teacher ratings
  - ☐ Record of extra-curricular activities
  - ☐ Individualized education programs
  - ☐ Psychological reports
  - ☐ Medical reports
  - ☐ Psychiatric reports
  - ☐ Other:

CONSENT OF PARENT/GUARDIAN FOR RELEASE OF INFORMATION

I authorize Chagrin Falls Exempted Village School District and the above named individual/organization/agency to exchange information and records as indicated. Except as limited above, this authorization encompasses all information pertaining to the minor, including protected health information (PHI) as defined in the Health Insurance Portability and Accountability Act (HIPAA) and its implementing regulations, and education records as defined in the Family Educational Rights and Privacy Act (FERPA) and R.C. 3319.321.

We expressly waive all provisions of law (including, but not limited to, the privacy provisions of HIPAA, FERPA, and R.C. 3319.321), forbidding any physician or other person who has or may hereafter treat, attend, or examine the minor, or any educational agency, from disclosing any knowledge or information, including PHI, which they may have thereby acquired.

Pursuant to HIPAA, the following are specified as part of this authorization:

A. The purpose of disclosure is for assisting the School District in offering the student a free appropriate public education pursuant to Section 504 of the Rehabilitation Act of 1973.

B. This authorization expires one (1) year after the date it is signed.

C. The parents signing this permission form understand that they may revoke this authorization at any time by providing written notification to the District Compliance Officer, the building principal/Building Compliance Officer, or the individual/organization/agency listed above, except to the extent that this authorization has already been relied upon.

D. The parents signing this form have been informed that the individual/organization/agency listed above may not condition treatment, payment, enrollment, or eligibility for benefits on whether the parents sign this authorization.

E. The parents signing this form have been informed of the potential for information disclosed pursuant to this authorization to be subject to redisclosure by the recipient and to be no longer protected by HIPAA. The parents signing this form are also aware that any information disclosed to the School District is subject to other state and Federal privacy laws.

_____ _____ _____

Parent's Signature Relationship to Student Date Signed

_____ _____

Address Phone Number