**Consent to Obtain and Release Information**

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| --- |
| Child’s Name:       Birth date:       Gender:        |
| Address:        |
| Parent/Guardian:       |
| Relationship to Child:       |
| Child’s School District/Building:       |

I authorize the following agency to release information to and to share information with the Urbandale Community School District for the purpose of this child’s and family’s participation in educational programming and services.

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| --- |
| Name/Agency:      Individual/Position:      Address:      Phone:      Local School Contact:       Phone:       |

I authorize the above listed individual/agency to share both written and oral information regarding the child’s needs and provision of services.

This may include information about:

* Physical status (including vision and hearing); communication skills, cognitive skills, social and emotional behavior, self-help skills, and health status (medical, dental, nutrition)
* Educational assessment, programming and services
* Social/Student functioning and family information
* Participation and progress with agency intervention
* X-Rays, charts, photographs

Other

I understand this information shall be kept confidential and shall be used only for purposes of planning and coordinating educational programming and services. I understand that I have the right to see this information by contacting the agency receiving it. I have read or have had explained to me the safeguards listed on the next page of this form.

This release shall expire at the end of one year or the date specified below by the authorizing party. This consent is valid for information currently in existence and information generated during future service involvement up to the expiration date of this authorization. I understand that I may revoke my consent at any time by providing written notification to the service coordinator.

|  |  |  |  |
| --- | --- | --- | --- |
| Authorizing signature | Date | Relationship to child | Expiration date |

**SPECIFIC AUTHORIZATION FOR RELEASE**

I authorize the release of the following information protected by federal/state law: (If release is authorized, signature required.)

Mental health evaluation/treatment\* Signature Date

 (Self/Parent/Guardian)

Substance abuse\* Signature Date

 (Self/Parent/Guardian)

HIV-related information\* Signature Date

 (Self/Parent/Guardian)

Mail information requested above to the Case/Service Coordinator at the address listed below:

Case/Service Coordinator       Phone

Address

Continuation

\*Only a person 18 years of age or his/her legal representative may authorize release of mental health information.

\*\*Only the subject may authorize release of substance abuse information unless the subject is under legal age or incompetent as defined by statute.

 **Distribution of this form:**

It is the Case/Service Coordinator’s responsibility to forward copies of this form to the identified agency or individual. A copy must be provided to the person signing the authorization for exchange of information.

 **Sharing information:**

It will be the responsibility of all agencies listed to provide requested information. Each recipient agency is responsible for maintaining the confidentiality of the information.

 **NOTICE TO RECIPIENTS OF MENTAL HEALTH INFORMATION**

In accordance with the Iowa Mental Health Information Disclosure Act (Iowa Code, Chapter 228), a recipient of mental health information may redisclose this information only with the written authorization of the subject or the subject’s legal representative or as otherwise provided in Chapter 228 and 229. Unauthorized disclosure is unlawful and civil damages and criminal penalties may apply. Federal confidentiality rules (42 CFR Part 2) restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

 **NOTICE TO RECIPIENTS OF SUBSTANCE ABUSE INFORMATION**

This information has been disclosed from records whose confidentiality is protected by Federal law. Iowa Code, Chapter 125 and Federal regulations (42 CFR, Part 2) prohibit any further disclosure without the specific written consent of the person to whom the information pertains, or as otherwise permitted by such statute and regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

 **NOTICE TO RECIPIENTS OF HIV-RELATED TESTING INFORMATION**

This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any disclosure of the information without specific written consent of the person to whom it pertains, or as otherwise permitted by law. A general authorization for the release of medical or other information is not sufficient for this purpose. (Iowa Code Ch. 141.23) Federal confidentiality rules (42 CFR, Part 2) restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.