Consent and Information Exchange

A copy of this form is considered as valid as the original. The Contact Person will send copies of this form to all individuals/agencies listed below. Individuals/agencies listed are responsible for providing requested information.

We want to protect student and family confidentiality, while complying with both state and federal law, including but not limited to the Privacy Act of 1974. By signing this form, you are giving permission to the individual(s)/organization(s)/agency(ies) listed below to discuss student needs and share information.

- Child/Student_____ Birth date_____
  (Legal Last Name) (First) (MI) (Mo Day Yr)

- I give permission for the parties named below to release and receive written and verbal information as listed regarding the above named child/student for the purpose of_____
  _____
  .

- I understand that I may cancel permission by giving written notice to each party named below. I understand_____
  (Contact Person)
  _____
  (Position/Agency) (Phone #)
  can direct me to the shared information upon request.

- The following agencies and organizations will collaborate with one another in planning, coordinating, and delivering services to students receiving services under the program being administered by the Iowa City Community School District. Therefore, this form permits the use, disclosure and redisclosure of confidential information for the purpose stated above and delivery of said services.

  I understand that state and federal law prohibits persons that receive mental health, alcohol or drug abuse, and educational records from redisclosing those records without permission. I also understand that not every organization that may receive a record is required to follow federal HIPAA rules governing the use and disclosure of protected health information. I HEREBY GIVE PERMISSION TO THE PERSON(S), AGENCY(IES), AND ORGANIZATION(S) THAT RECEIVE RECORDS PURSUANT TO THIS AUTHORIZATION TO RELEASE AND REDISCLOSE THAT RECORD AND THE INFORMATION IN THAT RECORD TO OTHER PERSONS, ORGANIZATIONS, OR AGENCIES LISTED HEREIN FOR THE PURPOSES OUTLINED ABOVE, BUT FOR NO OTHER PURPOSE WHATSOEVER.

1. _____
   Name of Individual and/or Position and Agency Phone

   Address: _____

   Info to share: _____

_____

2. _____
   Name of Individual and/or Position and Agency Phone

   Address: _____

   Info to share: _____

3. _____
   Name of Individual and/or Position and Agency Phone

Address: _____

Info to share: _____

- I understand that this permission and release is valid for one year following its execution, and that this permission and release will **expire one year from today's date**. I understand that this permission and release may be revoked. I understand that if this permission is revoked, it may not be possible to continue to participate in certain programs. I will be informed of that possibility if I wish to revoke this permission. I also understand that records disclosed before this permission is revoked may not be retrieved. Any person, agency, or organization that relied on this permission may continue to use records and protected information as needed to complete work that began prior to the revocation of this permission.

Signature_____ Date:_____
Parent/Legal Guardian

Signature_____ Date:_____
Student

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW:
My signature authorizes release of all information relating to (check appropriate boxes):

☐ Mental Health/Psychological ☐ Substance Abuse ☐ HIV Status/AIDS related testing

☐ Other (specify)_____

- Signature _____ Parent/Legal Guardian Date
- Signature _____ Student Date

- Witness _____ Date: _____
Name of Individual and/or Position and Agency