BURLINGTON AREA SCHOOL DISTRICT

A community of learners committed to continuous improvement through a culture of dialogue and reflection"

100 NORTH KANE STREET
BURLINGTON, WI 53105

Phone: (262) 763-0210
Fax: (262) 763-0215

AUTHORIZATION TO OBTAIN AND RELEASE INFORMATION

Pupil Name: _____Date of Birth: _____Grade ____ School _____

INSTRUCTIONS: Complete one or both of the Authorization Statements below, place checkmarks by the information that may be disclosed and sign the authorization. In order to allow the exchange of information between the Burlington Area School District and the identified individual/entity, please check both of the Authorization Statements.

AUTHORIZATION STATEMENTS

- ☐ I hereby authorize the Burlington Area School District to disclose by any means (including written, oral or electronic means) the information indicated below regarding the pupil to:

Name: _____
Address: _____
AND/OR

- ☐ I hereby authorize above mentioned agency to disclose by any means (including written, oral or electronic means) the information indicated below to the Burlington Area School District.

Mail to: _____
ATTN: _____

INFORMATION TO BE DISCLOSED:

Education Information / Records
- ☐ Progress Report
- ☐ Behavioral Records
- ☐ Pupil Physical Health Records
- ☐ Psychological Records
- ☐ Special Education Records
- ☐ Outside Agency Records
- ☐ Law Enforcement Records

Health Information / Records

Patient Health Information (specify or indicate "all")

_____

- ☐ Alcohol/Drug Abuse Records
- ☐ Developmental Disabilities
- ☐ Mental Health Records
- ☐ HIV (AIDS) Records

Other Information Records
- ☐ Specify

_____

PURPOSE OF DISCLOSURE: The information is requested for the purpose of educational programming and service, medical evaluation and treatment, health assessment and planning, or other (specify, such as "at request of the individual").

ACKNOWLEDGEMENT:

Receive Records & Authorization – I understand that I have a right to a copy of the records that are disclosed and a right to a copy of the authorization.

Withdrawal of Authorization – I understand that I have a right to revoke this authorization, except to the extent that disclosure has already been made in reliance on this authorization. I understand that my revocation is effective only if it is in writing and it is submitted to the individual/entity that is releasing information.

Re-Disclosure of Health Information – I understand that if my child's health information is released pursuant to this authorization, it may be subject to re-disclosure by a person who receives the health information and may be not be protected by federal law.

Voluntary Authorization – I understand that a health care provider may not condition health care treatment, payment or eligibility for health plan benefits of whether or not I sign this authorization.

This permission is valid for one year from the date signed. A copy of this form is as effective as the original. I certify that I am the parent, legal guardian, personal representative of the above named pupil, or that I am the pupil and of majority age, and have authority to sign this release.

_____ _____
Signature Date

_____ _____
Print Name Relationship to Pupil (parent, guardian, personal representative or adult pupil)