BURLINGTON AREA SCHOOL DISTRICT

209 WAINWRIGHT AVENUE, BURLINGTON, WI 53105

(262) 763-0210

BASD.K12.WI.US

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 the 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 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)