ZUMBRO EDUCATION DISTRICT	**CONSENT TO RELEASE PRIVATE DATA**	☐ **Futures/CHOICE/Connections** ☐ **Area Learning Center** ☐ **Transitions 2 Success** 2002 Mantorville Avenue N. Kasson, MN 55944 Office: (507)634-2037 Fax: (507)634-2040

Student's Full Legal Name: _____ **Birthdate:** _____ **Age:** _____

Parent Name(s): _____

Primary Parent Address: _____ Phone: _____

I authorize Zumbro Education District # 6012, Kasson, MN: (Check either or both boxes, as needed)

☐ **To Release Information To:** ☐ **To Obtain Information From:**

Name/ Title/Organization:_____

Address: _____

Information to be shared:

☐ Health Records

☐ Psychological / Psychiatric Records and/or Reports

☐ County Social Work / Law Enforcement Report

☐ Medical Reports (including related services)

☐ Chemical Abuse / Dependency Report

☐ Counselor, Teacher, Staff Observations

☐ Official School Records (Name, Address, Birth date, Sex, Attendance Record, Grade Level, Grades, Class Rank, Standardized Test Results, Behavior Report)

☐ Other (Specify) _____

The purpose for the request _____

I understand that this authorization takes effect the day that I sign it. It expires on (date)_____ or no more than one year from the date of my signature. I also understand that I may change this authorization at any time.

I also understand that I may revoke this authorization at any time by providing a signed, written notice of revocation to the ZED School District. A photocopy or facsimile of this authorization has the same legal effect as the original.

In the case of protected health or medical information, I hereby authorize the healthcare provider to discuss, disclose, and otherwise release any and all medical records, medical data, and health data identified above to the ZED School District and its staff and representatives pursuant to the Health Insurance Portability and Accountability Act ("HIPAA") privacy regulations, 45 C.F.R. 164.508. I understand that the healthcare provider may not condition treatment, payment, enrollment or eligibility on whether I execute this authorization. Health and medical information that is disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by the privacy regulations promulgated pursuant to HIPAA. Records that are received by the School District may be protected from re-disclosure under the Family Education Rights Privacy Act and the Minnesota Government Data Practice Act.

_____ _____

Parent / Guardian Signature, or Student if age 18 or older **Date**

revised 5/2022