CONSENT TO RELEASE PRIVATE DATA

☐ **South Campus**
221 2nd Ave SW, Byron MN 55920
Phone: 507-775-2108
Fax: 507-775-2344

☐ **Area Learning Center/Transitions**
630 1st Ave NW, Byron MN 55920
Phone: 507-775-2083
Fax 507-775-2168

Student's Full Legal Name: ____ **Birthdate:** ________ **Age:** __________

Parent Name(s): ____

Primary Parent Address: ____ Phone: ___________________

I authorize Zumbro Education District # 6012, Byron 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

☐ County Social Work / Law Enforcement Report

☐ Chemical Abuse / Dependency Report

☐ Psychological / Psychiatric Records and/or Reports

☐ Medical Reports (including related services)

☐ 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**