COPPER COUNTRY INTERMEDIATE SCHOOL DISTRICT - SPECIAL EDUCATION DEPARTMENT

RELEASE OF INFORMATION FORM

Name of Student/Former Student:_____ Date of Birth:_____

Mailing Address:_____ City:_____ State:_____ ZIP:_____

Telephone Number:_____

REQUESTING AGENCY	SENDING AGENCY
Attn:	Attn:
Agency: **Copper Country Intermediate School District**	Agency:
Address: **809 Hecla Street**	Address:
City/State/ZIP: **Hancock, MI 49930**	City/State/ZIP:

SPECIFIC TYPE(S) OF RECORDS TO BE RELEASED

Educational Records:

□ Psychological testing and reports
□ Social work and/or counseling testing and reports
□ Speech and/or language testing and reports
□ Teacher-consultant testing and reports
□ Multi-disciplinary Evaluation Team (MET) Reports
□ Individualized Education Plans (IEPs)
□ Behavioral evaluations and reports, behavior plans and functional behavior analyses
□ Vocational or pre-vocational evaluations
□ Transcript of grades
□ Attendance records
□ Other (specify):_____

Medical, Psychological and Psychiatric Records for Physical and/or Mental Illness:

□ Discharge Summary
□ Diagnosis
□ Medications
□ Assessments
□ History and Physical
□ Treatment Plan Record
□ Information about Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), or other communicable and severe communicable diseases as defined by Public Act 174 of 1989.
□ Other (specify):_____

PURPOSE OF DISCLOSURE

□ To assist in determining eligibility for special education programs and/or services.
□ To assist in determining placement of the student/former student in special education programs and/or services, as well as the length and frequency of special education services to be provided.
□ To better serve the educational needs of the student/former student.

I authorize and request disclosure of all of the medical and educational records, and other information related to the student/former Student listed about (including paper, oral and electronic interchange) from the sending school/agency to the receiving school/agency Herein described, including permission to release the specific records checked above. I waive confidentiality of such records pursuant to the Family Education Rights and Privacy Act (FERPA) & the Health Insurance Portability and Privacy Accountability Act (HIPAA).

If the following box is checked, I agree to the exchange of such information between both parties: □

- I understand that this authorization is good for □ 12 months from the date signed; or □ until I cancel it in writing.
- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be re-disclosed to other parties within the school district.
- I understand that I may write to the Copper Country Intermediate School District to revoke this authorization at any time.
- I understand that I will receive a copy of this form from the Copper Country Intermediate School District and may request a copy at any time.
- I understand that I may ask the source to allow me to inspect or obtain a copy of material to be disclosed.
- I understand that I have the right to refuse to sign this authorization.
- I have read this form and agree to the disclosures above from the types of sources listed.

_____ _____ Relationship of signer to student/former student

Signature of Individual Authorizing Disclosure Date Signed (check one): □ Self □ Parent □ Guardian

_____ I certify that I know the person signing this form or am satisfied of this person's identity.

Signature of Witness